

41 FOR STATE HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
4922 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
L4860											
1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Southlawn</u>						c. LENGTH OF STAY IN 1b <u>5 months</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6324 Elkins Avenue</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Samuel Woodrow Anderson</u>						4. DATE OF DEATH <u>April 21 1960</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 30 1915</u>		9. AGE (in years last birthday) <u>44 yrs.</u>		10. IF UNDER 1 YEAR: Months <u>4</u> Days <u>14</u> Hours <u>14</u> Min. <u>14</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mechanic</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile</u>					
11. BIRTHPLACE (State or foreign country) <u>West Columbia S.C.</u>						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Jahn Anderson</u>						14. MOTHER'S MAIDEN NAME <u>Adele Lyon</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>						16. SOCIAL SECURITY NO. <u>219-16-0765</u>					
17. INFORMANT <u>Margaret H Anderson</u>						Address <u>3237 Denochling St Wash DC 23, SE</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>420.1 Coronary Thrombosis</u>											
DUE TO (b) <u>Coronary atherosclerosis</u>											
DUE TO (c) <u></u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.											
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
CHIEF MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED <u>4-21-60</u>					
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-23-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ALL Faiths</u>				22d. LOCATION (City, town, or country) (State) <u>New Market Md.</u>			
23. FUNERAL DIRECTOR <u>The HUNTT Funeral Home, Waldorf, Md.</u>						24a. REC'D BY REGISTRAR <u>APR 25 '60</u>					
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>											

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

James I. Boyd

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

4-21-60

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or country) (State)

23. FUNERAL DIRECTOR

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

The HUNTT Funeral Home, Waldorf, Md.

DATE APR 25 '60

Arthur S. Kraus

U.S. DEPARTMENT OF HEALTH
BUREAU OF PUBLIC HEALTH
DIVISION OF LABORATORY MEDICINE
WASHINGTON, D.C. 20001

RECEIVED
JUL 1 1964
U.S. DEPARTMENT OF HEALTH
BUREAU OF PUBLIC HEALTH
DIVISION OF LABORATORY MEDICINE
WASHINGTON, D.C. 20001

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TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]
DATE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4912

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. LENGTH OF STAY IN 1b <u>17 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>076 Eugene Leland Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Raymond</u> Middle <u>Paul</u> Last <u>Arneson</u>				4. DATE OF DEATH 4 - 15 1960			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-24-13</u>	
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cab Driver</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>James Arneson</u>				14. MOTHER'S MAIDEN NAME <u>Caraco, Mabel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Wife - From Hospital/Record - As above</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Primary Carcinoma of Lung</u> <u>162.1</u> DUE TO <u>with Metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Mar 18, 1960</u> to <u>Apr 15, 1960</u> , that I last saw the deceased alive on <u>Apr 14, 1960</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L W Malin</u> M.D.				ADDRESS (Street, city or town, state) <u>Riverdale, Md</u>			
DATE SIGNED <u>5-15-60</u>							
PHYSICIAN'S NAME (Type) <u>L W Malin MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-18-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. [unclear]</u>				ADDRESS <u>517 WASHINGTON</u>		24a. REC'D BY REGISTRAR <u>APR 19 1960</u>	
				24b. REGISTRAR'S SIGNATURE <u>[unclear]</u>			

CERTIFICATE OF DEATH 1912

1.21.1

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTY OF BIRTH		STATE OF BIRTH	
JAMES H. HARRIS		Male		45		Jan 1, 1867		Baltimore		Baltimore		Baltimore		Maryland	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH	
Carpenter		Heart Disease		Natural		Several Months		Jan 10, 1912		Baltimore		Baltimore		Baltimore	
FATHER'S NAME		MOTHER'S NAME		MARRIED		SINGLE		WIDOWED		DIVORCED		DATE OF MARRIAGE		PLACE OF MARRIAGE	
John H. Harris		Mary E. Harris		Yes		No		No		No		Jan 1, 1885		Baltimore	
EDUCATION		RELIGION		POLITICAL PARTY		MILITARY SERVICE		NATIONALITY		RACE		COLOR		SCARS	
High School		Roman Catholic		Democratic		None		American		White		White		None	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS ACCIDENT		PREVIOUS POISONING		PREVIOUS DRUGS		PREVIOUS ALCOHOL		PREVIOUS TOBACCO	
None		None		None		None		None		None		None		None	
PREVIOUS DEATHS		PREVIOUS BURIALS		PREVIOUS CREMATIONS		PREVIOUS AUTOPSIES		PREVIOUS EXHUMATIONS		PREVIOUS REINTERMENTS		PREVIOUS REINTERMENTS		PREVIOUS REINTERMENTS	
None		None		None		None		None		None		None		None	
PREVIOUS DEATHS		PREVIOUS BURIALS		PREVIOUS CREMATIONS		PREVIOUS AUTOPSIES		PREVIOUS EXHUMATIONS		PREVIOUS REINTERMENTS		PREVIOUS REINTERMENTS		PREVIOUS REINTERMENTS	
None		None		None		None		None		None		None		None	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTER OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT, BALTIMORE, MARYLAND, FOR THE PURPOSE OF RECORDING AND INDEXING.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 11. See: Birth Cert. et

CERTIFICATE OF DEATH

Reg. Dist. No.

4848

4802

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Washington, D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				d. STREET ADDRESS 1818 Ingleside Terrace, NW			
3. NAME OF DECEASED (Type or print) Baby Boy				4. DATE OF DEATH April 17 1960			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/31/60	
9. AGE (In years lost birthday) 18		IF UNDER 1 YEAR 18		IF UNDER 24 HRS. 18		IF UNDER 1 YEAR 18	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Cheverly, Maryland				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Terry Baco te				14. MOTHER'S MAIDEN NAME ALMA ARRINGTON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) atelectasis 762.5 DUE TO Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 3/31 , 19 60 , to 4/17 , 19 60 that I last saw the deceased alive on 4/17/60 , 19 60 , and that death occurred at 6:55P from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas A. Christensen M.D.				ADDRESS (Street, city or town, state) P. G. G. Hospital DATE SIGNED 4/18/60			
PHYSICIAN'S NAME (Type) Cheverly, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 4/18/60		22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W Penn, Jr ADDRESS Administrator				24a. REC'D BY REGISTRAR APR 21 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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4923

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Deerwood Pk.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Deerwood Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deerwood Pk.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Butler</u> Last <u>Fitchison</u>				4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>64</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>So. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Howard Atchison</u>				14. MOTHER'S MAIDEN NAME <u>Annie Watson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>445X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>HYPERTENSION - (Malignant)</u> DUE TO (c) <u>—</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u> <u>1 year</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I attended the deceased from <u>Dec 15</u> , 19 <u>58</u> to <u>April 13</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4-13</u> , 19 <u>60</u> , and that death occurred at <u>4:45</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Harrison C Belden</u> M.D. <u>4423 - HUNT PL - ME</u>							
PHYSICIAN'S NAME (Type) <u>Harrison C Belden M.D.</u> <u>WASH - 19 - D.C.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>4/18/60</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Mem. Cemetery Suitland Rd. Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S Washington 4825 Deane</u> ADDRESS <u>ROBNE</u>				24a. REC'D BY REGISTRAR DATE <u>APR 18 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

331X

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS 5309 Taussig Rd.							
3. NAME OF DECEASED (Type or print) First Lula		Middle JENKINS		Last Bailey		4. DATE OF DEATH Month April		Day 23		Year 1960	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 8, 1878		9. AGE (In years lost birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) STERLING, VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Henry L. Jenkins		14. MOTHER'S MAIDEN NAME Jenny Jenkins									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) NONE		INFORMANT MRS. Zelda S. Elsner, 5220 Shorrie Pl. N.W.D.C.		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Acute Myocardial infarction		CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Coronary thrombosis, acute		(c) Arteriosclerotic hypertensive Cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH 2 days 2 day			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE. CONDITION GIVEN IN PART I (a)		Diabetes mellitus, Severe									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from May 1959 to April 23, 1960 and that death occurred at 11:10 PM from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 5304 Annapolis Road		DATE SIGNED William D. Rosson M.D.							
ACTUAL SIGNATURE William D. Rosson		PHYSICIAN'S NAME (Type) Dr. W. Rosson		Bladensburg		Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-27-60		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) Suitland, Md.					
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Riverdale, Md.		ADDRESS		24a. REC'D BY REGISTRAR APR 26 '60		24b. REGISTRAR'S SIGNATURE C. L. King & Sons					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4924

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

64805

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>74 Beltsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>11102 Baltimore Avenue</u>			d. STREET ADDRESS <u>4814 Powdermill Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>Payne</u> Last <u>Baldwin</u>			4. DATE OF DEATH Month <u>April</u> Day <u>27</u> Year <u>19 60</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-1- 1913</u>		9. AGE (In years last birthday) <u>47</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waitress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	12. CITIZEN OF WHAT COUNTRY? <u>usa</u>
13. FATHER'S NAME <u>Robert Bada Payne</u>			14. MOTHER'S MAIDEN NAME <u>Lillie Richardson</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>James Payne, Roanoke, Virginia</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gunshot wounds of chest</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Deceased was shot by another person.</u>			
20c. TIME OF INJURY Hour <u>2.15</u> p. m. <u>XX</u> Month, Day, Year <u>4-27 19 60</u>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>restaurant</u>		20f. (City or town) <u>Beltsville</u>	(County) <u>Pr. Geo.</u>
(State) <u>Md.</u>					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>John T. Maloney</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>John T. Maloney, M.D.</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>4-30-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sherwood Cemetery</u>
		22d. LOCATION (City, town, or county) <u>Salem</u>		(State) <u>Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Basch's Sons</u>			24a. REC'D BY REGISTRAR <u>DATE MAY 2 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any duty is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

4850

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 18 Hrs 25 Min			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Grace E Barrows				4. DATE OF DEATH April 9 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/26/63	
9. AGE (In years lost birthday) 96 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maine	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Josephxx Joseph Rideout				14. MOTHER'S MAIDEN NAME Corlena Soule			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT Mrs H.D. Wilson-Daughter				Address 6903-Oakridge St Hyattsville, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra Cerebral & cerebellar hemorrhage 331X DUE TO fract 2-3 ribs right multiple Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Ecchymosis DUE TO Cerebral arterio-sclerosis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 day 1 day							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 4-8 60 , to 4-9 60 , that I last saw the deceased alive on 4-9 60 , and that death occurred at 5:45 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE W.L. Etienne				ADDRESS (Street, city or town, state) 4713 Barways Rd College Park, Md			
PHYSICIAN'S NAME (Type) W.L. ETIENNE				DATE SIGNED 4/10/60			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		4-13-60		St. Lincoln		Colman Manor Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.W. Lees				ADDRESS Wash D.C.			
24a. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE			
DATE APR 13 '60				Arthur S. Hanna			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

33/x

John George ...

John George ...

John George ...

John George ...

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John George ...

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/5B

VS A15 (4)
15M 9/5B

1. PLACE OF DEATH o. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 24 Hr,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville 03X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		d. STREET ADDRESS 7520 Seven Miles Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle A. Last Basel		4. DATE OF DEATH Month Apr. Day 30 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 4, 1887	9. AGE (In years lost by day) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY MUSICIAN		11. BIRTHPLACE (State or foreign country) BALTIMORE, Md	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ?		16. SOCIAL SECURITY NO. INFORMANT		Address 8507 Fremont MR. CHARLES H. BASEL - Hyattsville	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Intracerebral hemorrhage DUE TO (b) Atherosclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH 13 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from Apr. 29 , 19 60 , to Apr. 30 , 19 60 , that I last saw the deceased alive on Apr. 30 , 19 60 , and that death occurred at 1:20P M., from the causes and on the date stated above.					
ACTUAL SIGNATURE Peter J. ...		ADDRESS (Street, city or town, state) Prince George Hosp.		DATE SIGNED 4/30/60	
PHYSICIAN'S NAME (Type) Cheverly - Md					
22a. BURIAL, CREMATION, REMOVAL (Specify) 5/3/60	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY SACRED HEART	22d. LOCATION (City, town, or county) (State) BALTIMORE Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Leonard ...		ADDRESS 5305 ...	24a. REC'D BY REGISTRAR DATE MAY 3 '60	24b. REGISTRAR'S SIGNATURE Arthur S. ...	

4821

Howard

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 23 District Heights	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hosp.		d. STREET ADDRESS 7600 District Heights Parkway	
3. NAME OF DECEASED (Type or print) First Middle Last William Dudley Baynes		4. DATE OF DEATH Month Day Year April 6, 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-31-1910
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR If UNDER 1 YEAR Mpnths Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Spray Painter		10b. KIND OF BUSINESS OR INDUSTRY Painting	
11. BIRTHPLACE (State or foreign country) N. Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Walter M. Baynes		14. MOTHER'S MAIDEN NAME Laura Mosley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 243-10-5869	
17. INFORMANT Address Ruby Bayne; same address as # 2.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO (b) Asphyxia Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. Hemorrhage into bronchi in the course of bronchoscopy and biopsy.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia in right middle lobe.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) See 18-c.	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 10:40 p. m. 4-6- 19 60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) Cheverly (County) Pr. Geo. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		DATE SIGNED April 6, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-9-60	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) Suitland (State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers & Son		ADDRESS 517-11th St. S.E.	
24a. REC'D BY REGISTRAR DATE APR 11 '60		24b. REGISTRAR'S SIGNATURE Arthur L. France	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
AGE _____		DATE OF BIRTH _____	
PLACE OF BIRTH _____		OCCUPATION _____	
MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		DATE OF MARRIAGE _____	
NAME OF SPOUSE _____		NAME OF CHILD(REN) _____	
NAME OF NEXT OF KIN _____		ADDRESS _____	
CITY _____		STATE _____	
ZIP CODE _____		COUNTY _____	
DATE OF DEATH _____		TIME OF DEATH _____	
PLACE OF DEATH _____		CAUSE OF DEATH _____	
MANNER OF DEATH <input type="checkbox"/> NATURAL <input type="checkbox"/> ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE		MEDICAL HISTORY _____	
PRESENT ILLNESS _____		TREATMENT _____	
SIGNATURE OF MEDICAL EXAMINER _____		SIGNATURE OF WITNESS _____	
PRINTED NAME OF MEDICAL EXAMINER _____		PRINTED NAME OF WITNESS _____	
LICENSE NUMBER _____		EXPIRATION DATE _____	

4925

64869

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchellville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Mitchellville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION --		d. STREET ADDRESS --	
3. NAME OF DECEASED (Type or print) First Middle Last Joseph Leslie Beall, Sr.		4. DATE OF DEATH Month Day Year April 7, 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 24, 1904
9. AGE (In years lost birthday) 55 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tobacco Farming		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Franklin Beall		14. MOTHER'S MAIDEN NAME Martha Tayman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No --		16. SOCIAL SECURITY NO. --	
INFORMANT Doris R. Beall-same as above.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410X Coronary Thrombosis - DUE TO (b) Mitral Stenosis - DUE TO (c) Auricular Fibrillation - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 1 Year 10 yrs 8 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis -			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) M	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb 15, 1960, to Apr 7, 1960, that I last saw the deceased alive on Apr 6, 1960, and that death occurred at 8:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James G. Sasscer		DATE SIGNED Apr 7 1960	
PHYSICIAN'S NAME (Type) James G. Sasscer, M. D.		ADDRESS (Street, city or town, state) Upper Marlboro, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/11/60	22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cath. Cem.	22d. LOCATION (City, town, or county) (State) Annapolis, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Funeral Home - Marlboro, Md.		24a. REC'D BY REGISTRAR DATE APR 18 '60	24b. REGISTRAR'S SIGNATURE Arthur L. Howard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

41

17

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1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4853

64810

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>61 Hyattsville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Edward George Beck</u>				4. DATE OF DEATH <u>April 9 1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 16, 1908</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>General Cashier C & P 2d. Co</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Washington D.C.</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Edward George Beck</u>				14. MOTHER'S MAIDEN NAME <u>Nathaniel Zellars</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>577-01-2823</u>			
17. INFORMANT <u>George F Beck - Same address -</u>				Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis</u> 577X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral aneurysm</u> DUE TO (c) <u>Evisceration & surgery for lysis of abdominal adhesions</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John T. Maloney</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>John T. Maloney, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>April 9, 1960</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/12/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Malley's Funeral Home</u> ADDRESS <u>Mt. Rainier, Md.</u>				24a. REC'D BY REGISTRAR <u> </u> DATE <u>APR 13 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

[Faint, mostly illegible text and markings on a medical certificate form, including fields for patient information, cause of death, and examiner details.]



7



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64811

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Laura Mae Bell				4. DATE OF DEATH April 4, 1960			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 28, 1960	
9. AGE (In years last birthday) 27 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Eugene Bell				14. MOTHER'S MAIDEN NAME Delouis Bell			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Eugene Bell Lathian Md.			
17. INFORMANT				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exhaustion 57110 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Gastro-enteritis DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) April 4, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-7-60		22c. NAME OF CEMETERY OR CREMATORY Mt. Zion		22d. LOCATION (City, town, or country) (State) Lathian Md.	
23. FUNERAL DIRECTOR William Reese, Jr. - Annapolis, Md.				24a. REC'D BY REGISTRAR DATE APR 13 '60			
				24b. REGISTRAR'S SIGNATURE Arthur S. Howard			

VS. A15ME
5/7/59

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4855

CERTIFICATE OF DEATH

14812
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 42 Cheverly			
c. LENGTH OF STAY IN 1b 2 da.				d. STREET ADDRESS 2218 Cheverly Ave.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Baby Boy A Middle Bissell Last 			4. DATE OF DEATH Month April Day 21 Year 19 60				
5. SEX Male		6. COLOR OR RACE W.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-19-60	
9. AGE (In years last birthday) 2 da.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY Maryland,		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas R.				14. MOTHER'S MAIDEN NAME Katheryn A. Warder			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity - 28 wks gestation DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/19 , 19 60 , to 4/20 , 19 60 , that I last saw the deceased alive on 4/20 , 19 60 , and that death occurred at 4:50 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4410 74th Ave. Bellemead, Md. DATE SIGNED 							
ACTUAL SIGNATURE Dr. Chas. D. Connor, M.D.				PHYSICIAN'S NAME (Type) Dr. Chas. D. Connor, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 4/26/60		22c. NAME OF CEMETERY OR CREMATORY Prince Georges General Hospital, Cheverly, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W Penn, Jr Administrator				24a. REC'D BY REGISTRAR APR 28 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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VS A15 (4)
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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WIDE WORLD

1



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4856

CERTIFICATE OF DEATH

64813

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 42 Cheverly			
c. LENGTH OF STAY IN 1b 1 hr				d. STREET ADDRESS 1 2218 Cheverly Avenue			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Baby Boy "B" Bissell		First Middle Last		4. DATE OF DEATH April 20 1960		Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 April 1960		9. AGE (In years last birthday) yrs. 1	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Thomas R Bissell				14. MOTHER'S MAIDEN NAME Katherine Warder			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 778X IMMEDIATE CAUSE (a) Prematurity - 5 mo. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Apr. 19 1960 , to Apr. 20 1960 and that death occurred at 12.05A , from the causes and on the date stated above. olive on Apr. 19 1960 , and that death occurred at 12.05A , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE D. Connor, M.D.							
PHYSICIAN'S NAME (Type) Dr. Connor, M.D. Cheverly., Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 4/26/60		22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr. Administrator.				24a. REC'D BY REGISTRAR DATE MAY 2 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

22 773816XV0

REPORT OF THE COMMISSIONER OF HEALTH
ON THE
MORBIDITY AND MORTALITY IN THE STATE OF NEW YORK
FOR THE YEAR 1883

ALBANY: J. B. LIPPINCOTT & CO., PRINTERS.
1884.

THE STATE OF NEW YORK,
IN SENATE,
January 15, 1884.

REPORT OF THE COMMISSIONER OF HEALTH
ON THE
MORBIDITY AND MORTALITY IN THE STATE OF NEW YORK
FOR THE YEAR 1883.

ALBANY: J. B. LIPPINCOTT & CO., PRINTERS.
1884.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
Items 11, 13 & 14 Film G261 4/27/60 iwk 4814									
4857									
CERTIFICATE OF DEATH									
Reg. Dist. No.									
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine				
c. LENGTH OF STAY IN 1b 9 da.					d. STREET ADDRESS Box 311 Route 1				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last Lula S. Bonds					4. DATE OF DEATH Month 4 Day 13 Year 19 60				
5. SEX F.		6. COLOR OR RACE C.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7--22-90		9. AGE (In years lost birthday) 69 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Aquasco, Md. P.G.Co.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Louis Gross					14. MOTHER'S MAIDEN NAME Nancy Jenifer				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO. 52-06729944				
17. INFORMANT James Bond					Address Brandywine Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ① Renal failure 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pylonephritis, acute. DUE TO (c) ② Diabetes mellitus									
INTERVAL BETWEEN ONSET AND DEATH 2 wks Unk. Unk.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from April 4, 19 60 to April 13, 19 60 that I last saw the deceased alive on April 13, 19 60, and that death occurred at 4 P.M. from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) DATE SIGNED									
ACTUAL SIGNATURE [Signature] M.D.									
PHYSICIAN'S NAME (Type)									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial									
22b. DATE THEREOF 4/16/60									
22c. NAME OF CEMETERY OR CREMATORY St. Thomas									
22d. LOCATION (City, town, or county) (State) Baden P.O. Md.									
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS George L. Nelson Aquasco Md									
24a. REC'D BY REGISTRAR DATE APR 21 60									
24b. REGISTRAR'S SIGNATURE [Signature]									

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1

Chief of Police
New York City

John J. Edgar
Director

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4833

Item 11 Film G262 5/9/60 iwk

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				c. LENGTH OF STAY IN 1b 7 years			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4114 Farragut Street				d. STREET ADDRESS 4114 Farragut Street			
3. NAME OF DECEASED (Type or print) Rose Francis Bottomley				4. DATE OF DEATH April 28 19 60			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-10-17	
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Packer				10b. KIND OF BUSINESS OR INDUSTRY Medicines		11. BIRTHPLACE (State or foreign country) Phila. Penna	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Frank Frances				14. MOTHER'S MAIDEN NAME Elizabeth ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT T. J. Maloney		Address Charon Hill, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 976X IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO (b) Gunshot wound of head Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted gunshot wound.			
20c. TIME OF INJURY Month, Day, Year Hour XX p. m. 4-27 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Hyattsville Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF May 2, 1960		22c. NAME OF CEMETERY OR CREMATORY Arlington Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE MAY 2 '60	
				24b. REGISTRAR'S SIGNATURE Cirking & House		DATE April 28, 1960	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4858 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4816

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Clarence Edward Brewer		4. DATE OF DEATH Month Day Year April 30 19 60	
5. SEX Male	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 7 1909
9. AGE (in years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Williams		14. MOTHER'S MAIDEN NAME Flora Plowden	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes W.W. 2		16. SOCIAL SECURITY NO. 17. INFORMANT Agnes Duckett Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute congestive heart failure DUE TO (c) Myocardosis			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Neoplasm; head of pancreas.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-5-1960	
22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines & Company		ADDRESS 3015 12th St., N. E.	
24a. REC'D BY REGISTRAR MAY 5 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hous	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. JONES		SEX Male		AGE 34		DATE OF BIRTH 12-1-1907	
PLACE OF BIRTH Baltimore, Md.		OCCUPATION Clerk		MARITAL STATUS Single		COLOR White	
STREET ADDRESS 1234 N. E. St.		CITY Baltimore		COUNTY Baltimore		STATE Md.	
DECEASED AT HOME <input checked="" type="checkbox"/>		DECEASED IN PLACE <input type="checkbox"/>		DECEASED IN TRANSIT <input type="checkbox"/>		DECEASED IN OTHER PLACE <input type="checkbox"/>	
CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural		MEDICAL HISTORY None		PRESENT ILLNESS None	
SIGNATURE OF EXAMINER J. H. Jones		SIGNATURE OF WITNESS J. H. Jones		SIGNATURE OF DECEASED J. H. Jones		SIGNATURE OF NEXT OF KIN J. H. Jones	
DATE OF EXAMINATION 12-1-1941		TIME OF EXAMINATION 10:00 AM		PLACE OF EXAMINATION Home		SIGNATURE OF DECEASED J. H. Jones	



RECEIVED
 DEPARTMENT OF HEALTH
 BALTIMORE, MD.

Item 25 Film G262 5/4/60 1wk
4926
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs				c. LENGTH OF STAY IN 1b N/A			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hospital Andrews, AAFB, Md				e. STREET ADDRESS 8349 Allendale Drive			
3. NAME OF DECEASED (Type or print) First Middle Last Newborn Male Brinkman				4. DATE OF DEATH Month Day Year April 24 1960			
5. SEX Male	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 24 April 1960	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A				10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME Bruce Herman Brinkman				14. MOTHER'S MAIDEN NAME Theresa Fay Simpson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. N/A		17. INFORMANT MOTHER		Address Same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Immaturity Premature birth							INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 24 , 19 60 , to April 24 , 19 60 , that I last saw the deceased alive on April 24 , 19 60 , and that death occurred at 1710 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED USAF Hospital Andrews Apr 24 60 Andrews AF Base, Md ACTUAL SIGNATURE John A. Moore M.D. PHYSICIAN'S NAME (Type) JOHN A. MOORE Captain USAF, MC ANDREWS AIR FORCE BASE, WASH 25, D.C.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE D. C. Morgue				24a. REC'D BY REGISTRAR DATE APR 28 '60		24b. REGISTRAR'S SIGNATURE Clifton S. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2050 274 XV 0

4860

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges				b. CITY OR TOWN (If outside corporate limits, write, RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 1hr.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland				b. COUNTY Charles				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf				d. STREET ADDRESS 08X-2				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General																															
3. NAME OF DECEASED (Type or print) First Kenneth				Middle Lee				Last Butler				4. DATE OF DEATH Month April				Day 2				Year 1960											
5. SEX Male				6. COLOR OR RACE Negro				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH Jan. 11, 1960				9. AGE (In years lost birthday) yrs. 32				IF UNDER 1 YEAR Months 21				IF UNDER 24 HRS. Hours 21				Min. 15			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant				10b. KIND OF BUSINESS OR INDUSTRY —				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? —																			
13. FATHER'S NAME James C. Butler				14. MOTHER'S MAIDEN NAME Theresa Briscoe																											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —				16. SOCIAL SECURITY NO. —				INFORMANT James C. Butler, Waldorf, Md				Address Waldorf, Md																			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) (c)				Bronschiopneumonia												INTERVAL BETWEEN ONSET AND DEATH 8 hrs.															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)																			
21. I certify that I attended the deceased from April 2, 1960 , to April 2, 1960 , that I last saw the deceased alive on April 2, 1960 , and that death occurred at 12:30 PM from the causes and on the date stated above.																															
ACTUAL SIGNATURE John W. Perkins				ADDRESS (Street, city or town, state) 5301 Hamilton St., Hyattsville, MD.				DATE SIGNED 4/4/60																							
PHYSICIAN'S NAME (Type) Dr. John Perkins, M.D.																															
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4-6-60				22c. NAME OF CEMETERY OR CREMATORY St. Peter's				22d. LOCATION (City, town, county) (State) Waldorf, Md																			
23. FUNERAL DIRECTOR'S SIGNATURE St. Anthon Funeral Home, Waldorf, Md				ADDRESS 4000 212 X V 4				24a. REC'D BY REGISTRAR DATE APR 8 '60				24b. REGISTRAR'S SIGNATURE Arthur L. Hines																			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Maryland

Robert C. Butler

James C. Butler, Maryland

1
FOR STATE
HEALTH DEPT.

TO DISTRICT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
4927 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04820

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residência before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Oxon Hill 40 years				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 17 Oxon Hill			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5100 Wheeler Road				d. STREET ADDRESS 15100 Wheeler Road			
3. NAME OF DECEASED (Type or print) Rose Anna Butler				4. DATE OF DEATH April 20 1960			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 30, 1884	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Gen Home			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY U.S.A			
13. FATHER'S NAME Stanislaus Proctor				14. MOTHER'S MAIDEN NAME Henrianna Carter			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. none			
17. INFORMANT William Harrison Butler				Address 5260 Oxon Hill Rd Wash 21, DC			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure							
DUE TO (b) Cardiovascular renal disease							
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James T. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James T. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) 4-21-68			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/25/60		22c. NAME OF CEMETERY OR CREMATORY Church Cemetery		22d. LOCATION (City, town, or country) (State) OXON HILL, MARYLAND	
23. FUNERAL DIRECTOR John T. Rhinest Co.				ADDRESS			
24a. REC'D BY REGISTRAR DATE APR 27 '60				24b. REGISTRAR'S SIGNATURE Arthur L. Rhine			

3015-14 STREETS. N.E. WASHINGTON D.C.

WILLIAM C. THOMPSON, JR., CHAIRMAN

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

<p>1. PLACE OF DEATH a. COUNTY MARYLAND</p>				<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges</p>			
<p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly</p>				<p>c. LENGTH OF STAY IN 1b 25 days</p>			
<p>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General</p>				<p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/></p>			
<p>3. NAME OF DECEASED (Type or print) First Beatrice Middle Chinn Last Chinn</p>				<p>4. DATE OF DEATH Month April Day 10 Year 19 60</p>			
<p>5. SEX Female</p>		<p>6. COLOR OR RACE Negro</p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH 10-17-92</p>	
<p>9. AGE (In years of birthday) 67</p>		<p>IF UNDER 1 YEAR Months Days Hours Min.</p>		<p>IF UNDER 24 HRS.</p>		<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife</p>	
<p>10b. KIND OF BUSINESS OR INDUSTRY None</p>		<p>11. BIRTHPLACE (State or foreign country) Wash., D. C.</p>		<p>12. CITIZEN OF WHAT COUNTRY? U. S. A.</p>		<p>13. FATHER'S NAME Robert F. Plummer</p>	
<p>14. MOTHER'S MAIDEN NAME Katie E. Cook</p>		<p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No</p>		<p>16. SOCIAL SECURITY NO. -</p>		<p>INFORMANT Jeanne E. Walton Address 4513 Kennedy St., Hyattsville</p>	
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 600.0 DUE TO Renal failure (clinical) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic pyelonephritis (c) Pancreatitis + Thrombotic Endocarditis</p>							
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></p>							
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>			
<p>20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.</p>				<p>20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/></p>			
<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>				<p>20f. (City or town) (County) (State)</p>			
<p>21. I certify that I attended the deceased from March 16 60 to April 10 60, that I last saw the deceased alive on April 10 60, and that death occurred at 3:15 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6111 Montrose Rd., Cheverly, Md. DATE SIGNED April 13 60</p>							
<p>ACTUAL SIGNATURE C. D. Connor M.D. 6111 MONTROSE RD. CHEVERLY, MD.</p>							
<p>PHYSICIAN'S NAME (Type) C. D. Connor 6111 Montrose Rd., Cheverly, Md.</p>							
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) Burial</p>		<p>22b. DATE THEREOF Apr-14-1960</p>		<p>22c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Cemetery</p>		<p>22d. LOCATION (City, town, or county) (State) Suitland, Md.</p>	
<p>23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines & Co. 3015 12th St., N. E.</p>				<p>24a. REC'D BY REGISTRAR DATE APR 13 '60</p>		<p>24b. REGISTRAR'S SIGNATURE Arthur S. Kraus</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

\$00.0

1
FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form M-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill out pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
4928 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 4822											
1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halls</u>						c. LENGTH OF STAY IN 1b <u>8 years</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Enterprise Road</u>						d. STREET ADDRESS <u>Enterprise Road</u>					
3. NAME OF DECEASED (Type or print) <u>Katie Catherine Cooper</u>						4. DATE OF DEATH <u>April 19 1960</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 1, 1875</u>		9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Stapleton Jett</u>						14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Carl J Cooper</u> Address <u>3713 Audens Rd Wash DC 20032 SE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>442x Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						DATE SIGNED <u>4-19-60</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>						22b. DATE THEREOF <u>APRIL 22/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>RAHOOTH BAPTIST CHURCH - STAFFORD Co. Virginia</u>		22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR <u>W.W. Chambers Co - 517-1155 SE. Wash. D.C.</u>						24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>		DATE <u>APR 21 '60</u>	

4862

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General</u>		d. STREET ADDRESS <u>4th + Lincoln Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Jane</u> Last <u>Cornelius</u>		4. DATE OF DEATH Month <u>April</u> Day <u>18</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-19-1914</u>
9. AGE (In years last birthday) <u>43</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u>	
11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry Coleman</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Mae Tate</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
INFORMANT <u>Willard Cornelius-Husband</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acidosis and electrolyte imbalance</u> DUE TO <u>Diabetes mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 17, 1960</u> to <u>April 18, 1960</u> , that I last saw the deceased alive on <u>April 18, 1960</u> , and that death occurred at <u>8:50 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. J. Connor, M.D.</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>CHEVERLY, MD.</u>	
PHYSICIAN'S NAME (Type) <u> </u>		<u> </u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>	22b. DATE THEREOF <u>4-23-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Harmony Park</u>	22d. LOCATION (City, town, or county) (State) <u>Sherriff Rd Ext Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H.S. Washington</u>		ADDRESS <u> </u>	
24a. REC'D BY REGISTRAR DATE <u>APR 25 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1862

January



1862



1862



1862



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4929

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE		c. LENGTH OF STAY IN 1b 2 HRS 4 Min	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NEWBORN Middle DAGEENAKIS Last DAGEENAKIS		4. DATE OF DEATH Month APRIL Day 7 Year 1960	
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 APRIL 1960
9. AGE (In years last birthday) yrs.		10. AGE (In years last birthday) yrs.	11. AGE (In years last birthday) yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME GEORGE A DAGEENAKIS		14. MOTHER'S MAIDEN NAME ELEANOR M HOLLIDAY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) NONE	
17. INFORMANT FATHER		Address SAME AS ABOVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ATELECTASIS, CONGENITAL 757.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) POLYCYSTIC KIDNEY, CONGENITAL DUE TO (c) PREMATUREITY		INTERVAL BETWEEN ONSET AND DEATH 2 hours 2 hours 2 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7 APRIL, 1960, to 7 APRIL, 1960, that I last saw the deceased alive on 7 APRIL, 1960, and that death occurred at 0230A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Stanley M Sinkford		DATE SIGNED 7 APRIL 1960	
PHYSICIAN'S NAME (Type) STANLEY M SINKFORD, CAPT USAF MC		ADDRESS (Street, city or town, state) USAF HOSPITAL ANDREWS	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF April 11, 1960	
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		22d. LOCATION (City, town, or county) (State) ARLINGTON VA.	
23. FUNERAL DIRECTOR'S SIGNATURE Kissall Funeral Home 816 H St. NE, Wash 200		24a. REC'D BY REGISTRAR DATE APR 11 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Kunkle		24c. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

1902

<p>NAME OF DECEASED</p>		<p>AGE</p>	
<p>SEX</p>		<p>DATE OF BIRTH</p>	
<p>PLACE OF BIRTH</p>		<p>DATE OF DEATH</p>	
<p>CAUSE OF DEATH</p>		<p>PLACE OF DEATH</p>	
<p>DATE OF INTERMENT</p>		<p>PLACE OF INTERMENT</p>	
<p>SIGNATURE OF REGISTRAR</p>		<p>DATE</p>	

X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4930

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHILLUM</u> c. LENGTH OF STAY IN lb <u>7 yrs.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>50 CHILLUM</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5425-SERGEANT RD.</u>		d. STREET ADDRESS <u>5425-SERGEANT RD.</u>	
3. NAME OF DECEASED (Type or print) First <u>ALMERINDO</u> Middle <u>Di</u> Last <u>NINNO</u>		4. DATE OF DEATH Month <u>April</u> Day <u>21</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-15-1885</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BRICKLAYER</u>	
11. BIRTHPLACE (State or foreign country) <u>ITALY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>PASQUALINO Di PAOLO</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or (unknown)) <u>NO</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>FAMILY</u>		Address <u>5425-SERGEANT RD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO <u>WITH CONGESTIVE FAILURE & FIBRILLATION</u> (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>5 YEARS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>11/4</u> , 19 <u>55</u> , to <u>PRESENT</u> , 19 <u> </u> , that I last saw the deceased alive on <u>4/14</u> , 19 <u>60</u> , and that death occurred at <u>8:30 A.M.</u> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Henry R. Wolfe</u>		ADDRESS (Street, city or town, state) <u>905 SHERIDAN ST. HYATTSVILLE, MD.</u>	
DATE SIGNED <u>4/21/60</u>		22. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	
22a. LOCATION (City, town, or county) <u>MD.</u>		22b. LOCATION (City, town, or county) <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy H. Nelson</u>		24a. REC'D BY REGISTRAR <u> </u>	
ADDRESS <u>3831 - GA. AVE. N.W.</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	
DATE <u>MAY 2 '60</u>			

CERTIFICATE OF DEATH

1930

[Faint, mostly illegible handwritten text follows, likely containing personal and medical details of the deceased.]

1
FOR STATE
HEALTH DEPT.
M

TO DEPT. OF HEALTH: This certificate should be executed within 24 hours after death. If any delay is necessary, please secure the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

099

16

2

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
4863 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 4867										
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. Co.					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly D.O.A.					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 19 Suitland					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hosp.					d. STREET ADDRESS 5220 Meadowbrook Drive					
3. NAME OF DECEASED (Type or print) CATHERINE MAY DIXON					4. DATE OF DEATH April 30th, 19 60					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 2nd, 1922		9. AGE (In years last birthday) 37 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Suitland, Md.		12. CITIZEN OF WHAT COUNTRY? USA		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13. FATHER'S NAME Carson Harker					14. MOTHER'S MAIDEN NAME Mary Schlorb					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. None		17. INFORMANT Carson H. Harker, Sr. 5220 Meadowbrook			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage & Shock 823 X DUE TO due to Crushed Skull Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Automobile Accident - off road					
20c. TIME OF INJURY Month, Day, Year 11:55 p.m. 4/29 1960					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 5900 Block Suitland Rd. Pr. Geo. Co., Md.					20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE James I. Boyd M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) James I. Boyd					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
					DATE SIGNED 4/30/1960					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF May 3, 1960		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem.		22d. LOCATION (City, town, or country) (State) Arlington, Va.	
23. FUNERAL DIRECTOR W.W. Chambers Co., 517--11th St. S.E.					ADDRESS Wash. D.C.		24a. REC'D BY REGISTRAR MAY 5 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

1203
MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4864

CERTIFICATE OF DEATH

4828

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 8 hrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS Rt. 1 Box 255			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Florence Middle M Last Dorsey		4. DATE OF DEATH		Month April Day 4 Year 19 60	
5. SEX Female	6. COLOR OR RACE Black	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30 Nov. 1931		9. AGE (In years lost birthday) 28 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James Marshall				14. MOTHER'S MAIDEN NAME Mary Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT Nelson H. Dorsey Address Upper Marlboro, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 467.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hemorrhage and Afibrinogenemia DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from APRIL 4, 1960 to APRIL 4 1960 that I last saw the deceased alive on APRIL 4, 1960 , and that death occurred at 5:10 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE John S. Haught M.D.							
PHYSICIAN'S NAME (Type) Dr. John Haught., M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/9/60		22c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial		22d. LOCATION (City, town, or county) (State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John S. Haught		ADDRESS 30 H Street, N.E.		24a. REC'D BY REGISTRAR APR 6 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Haught	

STATE OF TEXAS
OFFICE OF THE ATTORNEY GENERAL

IN RE: [illegible] [illegible] [illegible]

[illegible] [illegible] [illegible]

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4931

CERTIFICATE OF DEATH

04829

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY P.G. Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro, Md.		c. LENGTH OF STAY IN 1b Upper Marlboro, Md. X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3829-Marlboro Pike		d. STREET ADDRESS 3829-Marlboro Pike	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William First Curtis Middle Draper Last Sr.		4. DATE OF DEATH Month April Day 4 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 1, 1875
9. AGE (in years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months 8 Days 4 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Tobacco Merct.	
11. BIRTHPLACE (State or foreign country) Wash., D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William L. Draper		14. MOTHER'S MAIDEN NAME Lizzie A. Scott	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. None	
17. INFORMANT Rev. W. Curtis Draper		Address 3829-Marlboro Pike	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Conjunctive Heart Failure DUE TO (c) Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 2 hrs 2 months			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 1960 to Apr 4, 1960 , that I last saw the deceased alive on Mar 29, 1960 , and that death occurred at 10:35 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Upper Marlboro, Md - 4-5-60 DATE SIGNED James G. Sasscer M.D. ACTUAL SIGNATURE James G. Sasscer M.D. PHYSICIAN'S NAME (Type) James G. Sasscer, M.D. Upper Marlboro, Md.			
22a. BURIAL, CREMATION, OR OTHER DISPOSAL REMOVED		22b. DATE THEREOF 4-7-60	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Wm. Lee's Sons Co.		ADDRESS 300-4th St. N.E.	
24a. REC'D BY REGISTRAR DATE APR 7 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

CERTIFICATE OF DEATH

F.O. Co.

Prison George

Upper Marlboro, Md.

Upper Marlboro, Md.

3822-Prisoners like

3822-Prisoners like

William George

William George

White

White

U.S.A.

Robinson House, Wash. D.C.

Robinson

Alvin A. Boyd

Alvin A. Boyd

Alvin A. Boyd

Alvin A. Boyd

Alvin A. Boyd

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Pennsylvania b. COUNTY Montgomery ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville, Md.		c. LENGTH OF STAY IN 1b 2 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jenkintown Pa		75X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eleven Cedars Rest Home				d. STREET ADDRESS 251 Washington Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Gertrude Clymer Dunegan				4. DATE OF DEATH Month Day Year 4 11 1960			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 2, 1876		9. AGE (In years lost birthday) yrs. 83	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own Home		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Harry Clymer				14. MOTHER'S MAIDEN NAME Christine C Duneger Muirkirk, Md.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic vascular disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH 2 wk. 10 yr. +	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 2, 1959 to Apr 11, 1960 , that I last saw the deceased alive on Apr 11, 1960 , and that death occurred at 7 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE R. Bamer MD.				ADDRESS (Street, city or town, state) DATE SIGNED 2513 Buck Lodge Rd. 4-11-60			
PHYSICIAN'S NAME (Type) B. D. BAUER, M.D.				Adelphi			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/14/60		22c. NAME OF CEMETERY OR CREMATORY Beulah Cemetery		22d. LOCATION (City, town, or county) (State) New Briton, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F. Gasch's Sons Hyattsville Md.				24a. REC'D BY REGISTRAR DATE Apr 18 '60		24b. REGISTRAR'S SIGNATURE Clairmont S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

45

CERTIFICATE OF DEATH

Reg. Dist. No.

4831

4865

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 35 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lulia Middle Lanham Last Ellmore		4. DATE OF DEATH Month April Day 26 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 Sept. 1874
9. AGE (In years lost birthday) yrs. 85		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Loudoun County, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Minor Lanham		14. MOTHER'S MAIDEN NAME Catherine Ashby	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. C.F. Weadon; Same as Item # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 465X Pulmonary emboli; multiple DUE TO (b) Thrombosis of pelvic veins Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> ① Bronchopneumonia ② Arteriosclerosis ③ Diabetes mellitus			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-20, 1960, to 4-26, 1960 that I last saw the deceased alive on 4-26, 1960, and that death occurred at 2:15 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE David S. Clayman M.D.		ADDRESS (Street, city or town, state) 6311 Belts Ave - Riverdale, Md. DATE SIGNED 4/26/60	
PHYSICIAN'S NAME (Type) Dr. D. Clayman., M.D.		Riverdale., Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-27-1960	
22c. NAME OF CEMETERY OR CREMATORY Ketocin Cemetery		22d. LOCATION (City, town, or county) (State) Round Hill, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE F. J. J. Sons		24a. REC'D BY REGISTRAR ADDRESS Hyattsville, Md. DATE MAY 2 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1911

Frank J. Jones

Age

Married

Residence

City

State

County

Dec. 1st 1911

Dec. 1st 1911

Dec. 1st 1911

Dec. 1st 1911

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4852

4913

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riversdale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Laurel</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Beland Memorial Hosp</u>				d. STREET ADDRESS <u>Cherry Lane Rd</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Clarence</u> Middle <u>W.</u> Last <u>Everley</u>				4. DATE OF DEATH Month <u>April</u> Day <u>7</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>4-4-94</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Automobile Mechanic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Garage</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Albert W. Everley</u>				14. MOTHER'S MAIDEN NAME <u>Anna Eliza Dorsey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT Address <u>Hospital Record</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>501X</u> DUE TO <u>Extrinsic Pneumothorax</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Emphysema</u> DUE TO (c) <u>Acute Bacterial Pneumonia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs</u> <u>years</u> <u>years</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>4-7</u> , 19 <u>60</u> , to <u>4-7</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4-7</u> , 19 <u>60</u> , and that death occurred at <u>8:30</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>Roy B. Parsons</u> M.D.							
PHYSICIAN'S NAME (Type) <u>ROY B. PARSONS JR.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/10/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Emmanuel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Scaggville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u> </u> ADDRESS <u> </u>				24a. REC'D BY REGISTRAR <u> </u> DATE <u>APR 12 '60</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital, or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4933

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WASHINGTON b. COUNTY D. C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C. 47x3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suitland Nursing Home				d. STREET ADDRESS 515 LeBaum st, S. E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Violet Middle M Last FITCH				4. DATE OF DEATH Month April Day 26 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/9/1888	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY NONE	
11. BIRTHPLACE (State or foreign country) Washington, D. C.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Samuel Dean				14. MOTHER'S MAIDEN NAME Violet Dean Emma Child			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		(If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Thomas H. Fitch (son) Address 515 LeBaum St. S.E.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c) Generalized Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 4 hrs 5 yrs 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral arteriovenous with aneurysm						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1956, to April 26, 1960, that I last saw the deceased alive on April 25, 1960, and that death occurred at 1:47 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE John J. Baerly				ADDRESS (Street, city or town, state) 2904 Nichols Ave S.E. Wash, D.C.			
PHYSICIAN'S NAME (Type) John J. Baerly				DATE SIGNED 4-26-60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/28/60		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland Md	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home 300-4th St. N.E. Wash. D.C.				42a. REC'D BY REGISTRAR DATE APR 27 '60		24b. REGISTRAR'S SIGNATURE Arthur S. House	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

4866

CERTIFICATE OF DEATH

4834

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md.				c. LENGTH OF STAY IN 1b 9 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Hattie Middle M. Last Folkman				4. DATE OF DEATH Month April Day 19 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-1-88	
9. AGE (In years lost birthday) 71 yrs.		IF UNDER 1 YEAR Months 71 Days 71 Hours 71 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY BROOKLYN, N.Y.	
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME GEORGE ACKERMAN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. NONE			
INFORMANT ALBERT FOLKMAN, SON				Address GREEN BELT, MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, with hypotense and cardiac tamponade. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary thrombosis (c) Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 9 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Bladensburg, Maryland				(County) (State)			
21. I certify that I attended the deceased from Jan , 19 58 to April 19 , 19 60 , that I last saw the deceased alive on April 19 , 19 60 , and that death occurred at 10:00 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE William D. Ross				ADDRESS (Street, city or town, state) 5304 Annapolis Rd.			
DATE APR 22 '60				DATE SIGNED Arthur S. Kirsch			
PHYSICIAN'S NAME (Type) DR. ROSSON				BLADENSBURG, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-23-60		22c. NAME OF CEMETERY OR CREMATORY WASHINGTON NATIONAL		22d. LOCATION (City, town, or county) (State) SUITLAND, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Chamber L. Rivendale incl.				24a. REC'D BY REGISTRAR APR 22 '60			
24b. REGISTRAR'S SIGNATURE Arthur S. Kirsch							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chaverly				c. LENGTH OF STAY IN 1b 63			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEORGES GEN HOSPITAL				1 d. STREET ADDRESS 4810 48th AVE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First NELLIE Middle V. Last FRANKE				4. DATE OF DEATH Month APRIL Day 6 Year 1960			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 18, 1880	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Francis A. Dyer			14. MOTHER'S MAIDEN NAME unknown -Magruder				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]			16. SOCIAL SECURITY NO		17. INFORMANT Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY ARTERIO SCLEROSIS DUE TO Generalized arteriosclerosis (c) Generalized arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 17 years 7 years 20 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from 1955 , 19____, to 4-12- , 1960, that I last saw the deceased alive on 4-12- , 1960, and that death occurred at 9 P. M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Albert Roth			ADDRESS (Street, city or town, state) 5510 KANSAS AVE, RIVERDALE, MD		DATE SIGNED 4/7/60		
PHYSICIAN'S NAME (Type) ALBERT ROTH, MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4-9-60	22c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN		22d. LOCATION (City, town, or county) (State) BLADENSBURG, MARYLAND			
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Riverdale, Maryland			ADDRESS		24a. REC'D BY REGISTRAR DATE APR 11 '60	24b. REGISTRAR'S SIGNATURE Arthur L. Frame	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4934

CERTIFICATE OF DEATH

Reg. Dist. No. 14838

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Adelphi</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Faint Branch Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Pearl</u> First <u>C. (no name)</u> Middle <u>Freemire</u> Last				4. DATE OF DEATH <u>April</u> Month <u>11</u> Day <u>19</u> Year <u>60</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 14, 1888</u> 72 yrs. 4 Months 3 Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			
11. BIRTHPLACE (State or foreign country) <u>Cables Kill, New York</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Elmer Freemire</u>				14. MOTHER'S MAIDEN NAME <u>Julia Finch</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Nursing Home Records</u> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral & Generalized Arteriosclerosis</u> DUE TO (c) <u>4 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchopneumonia</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>28 May, 1957</u> , to <u>11 April, 1960</u> , that I last saw the deceased alive on <u>8 April, 1960</u> , and that death occurred at <u>8:55 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Russell B. Arnold</u> M.D.				ADDRESS (Street, city or town, state) <u>5801 Colesville Road, Silver Spring, Maryland</u>			
DATE SIGNED <u>4/11/60</u>							
PHYSICIAN'S NAME (Type) <u>Russell B. Arnold M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>April 15, 1960</u>		<u>South Valley Cemetery</u>		<u>Award, New York</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 254 Carroll St NW DC</u>				24a. REC'D BY REGISTRAR DATE <u>APR 14 '60</u>			
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

420.7

BORN

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		OCCUPATION	
EDUCATION		MARRIAGE	
PLACE OF BIRTH		DATE OF BIRTH	
PLACE OF DEATH		DATE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF JUDGE	
SIGNATURE OF CLERK		SIGNATURE OF NOTARY	
SIGNATURE OF CHURCH		SIGNATURE OF FUNERAL HOME	
SIGNATURE OF BURIAL		SIGNATURE OF INTERMENT	
SIGNATURE OF CREMATION		SIGNATURE OF OTHER	

RECEIVED BY THE STATE DEPARTMENT OF HEALTH - BALTIMORE 19

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4863

64837

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 04 Bowie	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Darrell Last Gallaher		4. DATE OF DEATH Month April Day 27 Year 1960	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-7-07
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder		10b. KIND OF BUSINESS OR INDUSTRY Iron works	11. BIRTHPLACE (State or foreign country) W. Virginia
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Asa Gallaher	
14. MOTHER'S MAIDEN NAME Mary Drain		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.	
16. SOCIAL SECURITY NO.		17. INFORMANT Address Jessie Gallaher; same address as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO (b) Ulcerative aortitis DUE TO (c) Aortic insufficiency CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 27, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/30/60	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE MAY 2 '60	
		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Pr. Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
c. LENGTH OF STAY IN 1b 2 1/2 yrs.		d. STREET ADDRESS 5604 Chillum Heights Drive #2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5604 Chillum Heights Drive #2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Kelly Middle McAway Last Garlock		4. DATE OF DEATH Month April Day 22 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 17, 1905
9. AGE (In years last birthday) 54 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John R. Garlock		14. MOTHER'S MAIDEN NAME Emma B. Chrissinger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 579-26-2596	
17. INFORMANT Mrs. Lila Bell Garlock		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Coronary Thrombosis DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiovascular - Renal Disease DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 1 hour 7 Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) One previous coronary; Several cerebral thromboses.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. j. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr. 15 , 19 58 , to April 22 , 19 60 , that I last saw the deceased alive on April 12 , 19 60 , and that death occurred at 7:10 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6001-35th Ave, Hyattsville, Md. DATE SIGNED 4/22/60			
ACTUAL SIGNATURE W. H. Clements		M.D. 6001-35th Ave, Hyattsville, Md.	
PHYSICIAN'S NAME (Type) Wm. H. Clements, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/26/60	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington, Va.
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home		24a. REC'D BY REGISTRAR Mr. Rainier DATE APR 25 60	
ADDRESS Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4935

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4840

Item 8 Film G261 4/27/60 iwk

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chillum				c. LENGTH OF STAY IN 1b 2 years			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 819 Somerset Place				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Frederick Middle Thomas Last Gordon				4. DATE OF DEATH Month April Day 17 Year 19 60			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-22- 1905 1904 55	
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months 5 Days 17		IF UNDER 24 HRS. Hours 17 Min. 00			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Utility Man				10b. KIND OF BUSINESS OR INDUSTRY Landscaping		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME James William Gordon				14. MOTHER'S MAIDEN NAME Elizabeth Griffin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-07- 7424		17. INFORMANT Irene Ghillani; same address as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) a (c) a							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				DATE SIGNED April 17, 1960			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/19/60		22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.				24a. REC'D BY REGISTRAR DATE APR 21 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

MEDICAL CERTIFICATION

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BALTIMORE, MARYLAND		DATE OF DEATH 1917	
NAME OF DECEASED JOHN J. JONES		SEX Male	
AGE 45 Years		OCCUPATION Carpenter	
PLACE OF BIRTH Baltimore, Md.		PLACE OF DEATH Baltimore, Md.	
MARITAL STATUS Married		CAUSE OF DEATH Heart Disease	
DATE OF BIRTH 1872		PLACE OF BIRTH Baltimore, Md.	
DATE OF DEATH 1917		PLACE OF DEATH Baltimore, Md.	
NAME OF PHYSICIAN Dr. J. H. Smith		NAME OF MEDICAL EXAMINER Dr. J. H. Smith	
SIGNATURE OF PHYSICIAN J. H. Smith		SIGNATURE OF MEDICAL EXAMINER J. H. Smith	
CERTIFICATE OF DEATH I hereby certify that the above named person died on the 17th day of 1917, at the age of 45 years, of Heart Disease.		I hereby certify that the above named person died on the 17th day of 1917, at the age of 45 years, of Heart Disease.	

ORIGINAL FILED IN 1917

204.

CERTIFICATE OF DEATH

Reg. Dist. No.

4843

4835

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6009-Belle Court</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>A.</u> Last <u>Grefe</u>		4. DATE OF DEATH Month <u>April</u> Day <u>4</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 20, 1900</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>State Dept.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>	
11. BIRTHPLACE (State or foreign country) <u>Jacksonville, Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Paul F. Alexander</u>		14. MOTHER'S MAIDEN NAME <u>Mary Gaiteness</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. Fred C. Grefe</u>		18. ADDRESS <u>6009-Belle Court, Hyattsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>			
420.1 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/1</u> , 19 <u>59</u> , to <u>4/4</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3/28</u> , 19 <u>60</u> , and that death occurred at <u>12:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Earl W. Graeff</u>		DATE SIGNED <u>4/4/60</u>	
PHYSICIAN'S NAME (Type) <u>EARL W. GRAEFF M.D.</u>		ADDRESS (Street, city or town, state) <u>2716 Kinkaid Place W. Hyattsville Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/6/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	22d. LOCATION (City, town, or county) (State) <u>Silver Spring Montgomery Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Valley's Funeral Home</u>		24. REC'D BY REGISTRAR <u> </u> DATE <u>APR 7 '60</u>	
ADDRESS <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Funn</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

1. Name of Deceased: _____

2. Sex: _____

3. Age: _____

4. Date of Birth: _____

5. Date of Death: _____

6. Place of Death: _____

7. Cause of Death: _____

8. Signature of Physician: _____

9. Signature of Registrar: _____

10. Date of Registration: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4936

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland. b. COUNTY Pr. Geo's. Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland, Maryland.		c. LENGTH OF STAY IN 1b 50- Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 112- Belgreen Street S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DALLAS Middle M. Last GRIGSBY		4. DATE OF DEATH Month April Day 11th. Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 4- 1881
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 7 Days 11 Hours 11 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic.	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs Lillian M. Wilson		Address 19- Kentucky Ave., S.E.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) URMIAE DUE TO 442X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Nephrosclerosis DUE TO Hypertensive arteriosclerotic C.V. Disease (c) Diabetes mellitus ; arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 10 days 6 months 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus ; arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-15, 1958 , to 4-11, 1960 , that I last saw the deceased alive on 4-11, 1960 , and that death occurred at 10:11 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE John J. Calarco		ADDRESS (Street, city or town, state) 3801 Suitland Rd S.E.	
PHYSICIAN'S NAME (Type) John J. Calarco M.D.		DATE SIGNED 4-11-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 13- 60	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Bladensburg, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Samson Bros 1661- 9th Ave NE Wash DC		24a. REC'D BY REGISTRAR APR 12 60	
24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

947X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 8 Film G262 5/16/60 jwk
4870
CERTIFICATE OF DEATH

44845
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 14 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 30 Cedar Heights			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				1d. STREET ADDRESS 61405 K St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles Hardy				4. DATE OF DEATH Month April Day 26 Year 1960			
5. SEX Male		6. COLOR OR RACE Black		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH unknown 1881	
9. AGE (In years lost birthday) 79		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ollie Hardy				14. MOTHER'S MAIDEN NAME Anna Seward			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 332X		INFORMANT Lena Redmond East Address Rothensond NJ			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis, cerebral blood vessel DUE TO (b) Arteriosclerosis, generalized. DUE TO (c) 14 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 12 1960 to April 26 1960 that I last saw the deceased alive on April 26 1960 , and that death occurred at 12.10 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE C. Connor				M.D. CHEVERLY MD			
PHYSICIAN'S NAME (Type) DR C. CONNOR							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
4-30-60		4-30-60		Mat. Harmony		Sheriff Rd. Md	
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington				ADDRESS 4935 Dean Ave		24a. REC'D BY REGISTRAR DATE MAY 2 '60	
						24b. REGISTRAR'S SIGNATURE Arthur S. Knaus	

4874

REPUBLIC OF CHINA



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4937

CERTIFICATE OF DEATH

64846
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Prince George's Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland, Maryland		c. LENGTH OF STAY IN 1 Week	
d. NAME OF HOSPITAL (If not in hospital, give street address) Suitland Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle HARPER Last HARPER		4. DATE OF DEATH Month April Day 27 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April -10- 1869
9. AGE (In years last birthday) 91 yrs.		10. IF UNDER 1 YEAR Months 14 Days 14 Hours 14 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME August Behmer		14. MOTHER'S MAIDEN NAME Katherine Bicking	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Herbert O. Harper	
17. ADDRESS Same as # 2.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure DUE TO Left C. V. A. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerosis (Cerebral) DUE TO Arteriosclerosis (Cerebral) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH - 14 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-27-1960 , to 4-27-1960 , that I last saw the deceased alive on 4-25-1960 , and that death occurred at 1:50 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1535 Good Hope Rd SE Wash DC DATE SIGNED 4-27-60 ACTUAL SIGNATURE Clarence L. Purdy, M.D. PHYSICIAN'S NAME (Type) Clarence L. Purdy 1535 Good Hope Rd Se Wash DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 30-1960	
22c. NAME OF CEMETERY OR CREMATORY Washington National Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros.		24a. REC'D BY REGISTRAR DATE APR 29 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Harris			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1937

John Doe, 1900

John Doe, 1900

John Doe, 1900

John Doe, 1900

John Doe, 1900

John Doe, 1900

John Doe, 1900

John Doe, 1900

John Doe, 1900

John Doe, 1900

John Doe, 1900

John Doe, 1900

John Doe, 1900

John Doe, 1900

John Doe, 1900

John Doe, 1900

John Doe, 1900

John Doe, 1900

Reg. Dist. No.

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/SS

420.0

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 107 16th Street	
3. NAME OF DECEASED (Type or print) First Samuel Middle Harvey, Jr. Last		4. DATE OF DEATH Month April Day 29 Year 19 60	
5. SEX Male	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-6-22
9. AGE (In years last birthday) 38 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance man		10b. KIND OF BUSINESS OR INDUSTRY Appliances	
11. BIRTHPLACE (State or foreign country) N Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Harvey		14. MOTHER'S MAIDEN NAME Addie Koonce	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1943-46 Army 579-18-7554	
17. INFORMANT Address Betty S. Harvey; same address as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Crushed chest and compound fracture of right tibia and fibula. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b) STOTING THE UNDERLYING CAUSE LOST. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in an auto. in collision with a guard rail	
20c. TIME OF INJURY Month, Day, Year 8:15 p.m. 4-29-60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	
20f. CITY OR TOWN (County) (State) near Kenilworth Pr. Geo. Mdd			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		DATE SIGNED April 30, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/5/1960	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W. Ernest Jarvis Co., Inc. 1432 You Street, N.W.		24a. REC'D BY REGISTRAR May 9 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Howard			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A15ME
5M 7/59

Item 20b Md. State Police 4-13-60											
MAYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
4872 MEDICAL EXAMINER'S CERTIFICATE OF DEATH (4840)											
1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>Prinice George's Gen. Hospital</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland, Maryland.</u> d. STREET ADDRESS <u>4478 Fort Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>John Daniel Hayden</u> First Middle Last 4. DATE OF DEATH <u>April 7 1960</u> Month Day Year						5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Nov. 3, 1952</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>7</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Suitland Elementary School</u> 11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>						13. FATHER'S NAME <u>Robert L. Hayden</u> 14. MOTHER'S MAIDEN NAME <u>Verna Soffjord</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service) 16. SOCIAL SECURITY NO. <u>none</u> 17. INFORMANT <u>Robert L. Hayden</u> Address <u>Same as #2</u>						18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and Shock</u> <u>812 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Due to crushed chest</u> (c) <u>Due to</u> (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>Motor vehicle with pedestrian</u>						20c. TIME OF INJURY Month, Day, Year <u>5:50 a.m. 4/7 1960</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Huron Rd. 40' from Lewis Ave. P.G. Md.</u> 20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>James I. Boyd</u> EXAMINER'S NAME (Type) <u>JAMES I. BOYD, MD.</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>April, 8, 1960</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>4-11-60</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u> 22d. LOCATION (City, town, or country) (State) <u>Suitland Maryland</u>						23. FUNERAL DIRECTOR <u>W.W. Chambers Eco Riverdale, Md</u> ADDRESS <u>APR 11 1960</u> 24b. REGISTRAR'S SIGNATURE <u>James I. Boyd</u>					

1875

1875

THE
OFFICE OF THE
SHERIFF
COUNTY OF
NEW YORK
IN SENATE
JANUARY 1875

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/5B

STATE OF CALIFORNIA

County of _____

Plaintiff

vs.

Defendant

County of _____

Plaintiff

vs.

Defendant

County of _____

Plaintiff

vs.

[Faint handwritten text, possibly a signature or name]

[Faint handwritten text, possibly a signature or name]



[Faint handwritten text, possibly a signature or name]

[Faint handwritten text, possibly a signature or name]

[Faint handwritten text, possibly a signature or name]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
Item 18 Film 261 4-29-60 ams											
4874											
CERTIFICATE OF DEATH											
Reg. Dist. No. 64851											
1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly						c. LENGTH OF STAY IN 1b 7 Days					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Robert Middle L Last Hinton						4. DATE OF DEATH Month April Day 15 Year 19 60					
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/18/56		9. AGE (In years lost birthday) 3 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---				10b. KIND OF BUSINESS OR INDUSTRY ---				11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Robert A. Hinton						14. MOTHER'S MAIDEN NAME Celestine Walls					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		INFORMANT Mother, Address Bowie, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 513X IMMEDIATE CAUSE (a) Septicemia DUE TO Ethmoiditis Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Apr. 8 , 19 60 , to Apr. 15 , 19 60 , that I last saw the deceased alive on Apr. 15 , 19 60 , and that death occurred at 7:30 PM , from the causes and on the date stated above.											
ACTUAL SIGNATURE John W. Perkins				ADDRESS (Street, city or town, state) 5301 Hamilton St., Hyattsville				DATE SIGNED 4/16/60			
PHYSICIAN'S NAME (Type) Dr. John Perkins, M.D.				5501 Hamilton St., Hyattsville, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4/19/60		22c. NAME OF CEMETERY OR CREMATORY Church of the Ascension		22d. LOCATION (City, town, or county) (State) Bowie, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE John J. Stewart				ADDRESS 30 H Street, N.E.		24a. REC'D BY REGISTRAR APR 19 1960		24b. REGISTRAR'S SIGNATURE Arthur L. Harris			

053.4

4875

CERTIFICATE OF DEATH

4852
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY P.G.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEORGES HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Jack First Noize Middle HIRSCH Last		A. DATE OF DEATH April 16 Month 16 Day 1960 Year	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 1, 1989
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Store		10b. KIND OF BUSINESS OR INDUSTRY Romania	
11. BIRTHPLACE (State or foreign country) Romania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Hirsch		14. MOTHER'S MAIDEN NAME Anna (Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Dorothy Litsky Address 135 E 57th St		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 4-12-1960 , 19 57 , to 4-16-1960 , that I last saw the deceased alive on 4-12-1960 , and that death occurred at 11:55 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Peter Duus		ADDRESS (Street, city or town, state) 6134 Central Ave	
PHYSICIAN'S NAME (Type) PETER DUUS		DATE SIGNED 4-16-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 19, 1960	
22c. NAME OF CEMETERY OR CREMATORY New Montefiore		22d. LOCATION (City, town, or county) (State) Farmingsdale Ld NY	
23. FUNERAL DIRECTOR'S SIGNATURE B. Danzansky ADDRESS Wash D.C.		24a. REC'D BY REGISTRAR APR 19 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

420.0

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "PETER" and "COUNT" are visible.]

4938

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SUITLAND, MARYLAND c. LENGTH OF STAY IN 1b SUITLAND, MARYLAND d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUITLAND NURSING HOME		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY P. Geo. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HILLCREST GARDENS d. STREET ADDRESS 5216- 31st PLACE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CLARA Middle BELLE Last HUDSON		4. DATE OF DEATH Month 4 Day 18 Year 1960	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/10/88	
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard J. Benson		14. MOTHER'S MAIDEN NAME Belle Murphy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Raymond F. Hudson		18. ADDRESS 58 E Ridge Rd. Greenbelt, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Heart Disease DUE TO (c) Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 4 hours 5 years 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1949 to April 18, 1960 , that (I) (we) last saw the deceased alive on March 9, 1960 , and that death occurred at 3:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE W. Robert Perkins		22b. DATE SIGNED 4/18/1960	
22c. PHYSICIAN'S NAME (Type) W. Robert Perkins		22d. ADDRESS 1463- Rhode Island Ave. NW.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 4/20/60	
23c. NAME OF CEMETERY OR CREMATORY Neelsville, Md.		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		25a. REC'D BY REGISTRAR APR 19 1960	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines		25c. ADDRESS Washington 9, D.C.	

VR AIS (4)
ISM 9/59

6032 CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G261 4/25/60 cap

4836

CERTIFICATE OF DEATH

Reg. Dist. No.

64855

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville c. LENGTH OF STAY IN 1b 62 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Private Home		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY prince georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 5311 42nd. Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES FRANKLIN Middle HUGHES Last S. SEX male 6. COLOR OR RACE white 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> B. DATE OF BIRTH 6-3-1899 9. AGE (In years last birthday) 60 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.		4. DATE OF DEATH Month April Day 18 Year 1960	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter 10b. KIND OF BUSINESS OR INDUSTRY Building 11. BIRTHPLACE (State or foreign country) Virginia 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William George Hughes 14. MOTHER'S MAIDEN NAME Laura Belle Payne	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. 16. SOCIAL SECURITY NO. ----- INFORMANT Elizabeth R. Hughes Address Hyattsville, MD 5311 42nd Ave.,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Insufficiency DUE TO Diffuse obstructive pulmonary emphysema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 10 years (c) 2 years		INTERVAL BETWEEN ONSET AND DEATH 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) Bronchogenic carcinoma (epithelioid pneumonoma)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. — p. m. — 19 60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 56 , to April 18, 1960 , that I last saw the deceased alive on March 28, 1960 , and that death occurred at 7:50 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James P. Mann PHYSICIAN'S NAME (Type) JAMES P. MANN		ADDRESS (Street, city or town, state) 1711 Rhode Island Ave N.W. Washington, D.C. DATE SIGNED 4/18/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 4-22-60 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery 22d. LOCATION (City, town, or county) (State) Suitland, Maryland		24a. REC'D BY REGISTRAR APR 21 1960 24b. REGISTRAR'S SIGNATURE Arthur S. Thoma	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Bowler's Sons ADDRESS Washington, D.C.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1938

Princess George's Hospital, Haverhill, Massachusetts

Haverhill, Massachusetts

3211 42nd Avenue

April 18, 1938

0-1-1938

U.S.A.

George H. Haverhill

George H. Haverhill

George H. Haverhill

George H. Haverhill

George H. Haverhill

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George H. Haverhill

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4914

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 10a, 10b Film G264, 6-17-60 et.

64856
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b 5 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 66 Riverdale			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital				e. STREET ADDRESS 5403 56th Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Delmer Middle Dexter Last Hurd				4. DATE OF DEATH Month April Day 22 Year 19 60			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 25, 1917		9. AGE (in years last birthday) 42 yrs.	IF UNDER 1 YEAR Months 42 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Taxicab driver Miner		10b. KIND OF BUSINESS OR INDUSTRY Stonega Coal & transportation		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hubert Hurd				14. MOTHER'S MAIDEN NAME Bobbie Cantwell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 224-03-8013		17. INFORMANT Georgia Hurd; same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c) Cardiovascular renal disease DUE TO cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal				22b. DATE THEREOF 4/23/60		22c. NAME OF CEMETERY OR CREMATORY Appalachia	
23. FUNERAL DIRECTOR'S SIGNATURE F Paschi some Hyattsville, Md				24a. REC'D BY REGISTRAR DATE APR 25 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hurd	
22d. LOCATION (City, town, or county) ra				22e. (State)			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06087

Reg. Dist. No.

4939

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Agassasco</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 381</u>				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Agassasco</u> d. STREET ADDRESS <u>Route 381</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
3. NAME OF DECEASED (Type or print) <u> Sinclair Ellsworth Hyde</u> First Middle Last				4. DATE OF DEATH Month <u>April</u> Day <u>29</u> Year <u>1960</u>													
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 3, 1892</u>		9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY (Own Farm) <u>Tobacco</u>				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Spencer Hyde</u>						14. MOTHER'S MAIDEN NAME <u>Anna Connick</u>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>						16. SOCIAL SECURITY NO. <u> </u>						17. INFORMANT <u>William P. Hyde, same as #2</u> Address <u> </u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> DUE TO (b) <u>Cardiovascular renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u> </u>														INTERVAL BETWEEN ONSET AND DEATH <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>											
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>				20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																	
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED <u>4/29/60</u>					
EXAMINER'S NAME (Type) <u>James I. Boyd</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>5/1/60</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Immanuel Cemetery</u>				22d. LOCATION (City, town, or county) <u>Horsehead</u> (State) <u>Md.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Funeral Home—Marlboro, Md.</u> ADDRESS <u>Upper</u>												24a. REC'D BY REGISTRAR <u> </u> DATE <u>MAY 11 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 5 & 6 Film G262 5/12/60 iwk

CERTIFICATE OF DEATH

Reg. Dist. No. **64857**

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u> c. LENGTH OF STAY IN 1b <u>8 mos.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) <u>3308-Buchanan Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u> <u>48</u> d. STREET ADDRESS <u>3308-Buchanan</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Thomas Wesley Tyson</u> First Middle Last 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>11/20/05</u> 9. AGE (In years last birthday) <u>54</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Months Days Hours Min.				4. DATE OF DEATH <u>4-30-1960</u> Month Day Year 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u> 11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> 13. FATHER'S NAME <u>John Francis Tyson</u> 14. MOTHER'S MAIDEN NAME <u>Mary Josephine Nicholson</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> 16. SOCIAL SECURITY NO. <u>Informant</u> INFORMANT <u>Margaret G. Tyson</u> Address <u>above</u> <u>Wife</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>163X</u> <u>cardiac hemorrhage</u> DUE TO (b) <u>Mitral valve disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Carcinoma of Lung</u> DUE TO (b) <u>5 months</u> DUE TO (c) <u>8 months</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/>								INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u> <u>5 months</u> <u>8 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Summer, 1959</u> , to <u>April 30, 1960</u> , that I last saw the deceased alive on <u>April 30</u> , 19 <u>60</u> , and that death occurred at <u>315</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3408 Rhode Island Ave</u> DATE SIGNED <u>4/30/60</u> ACTUAL SIGNATURE <u>And Lentsky</u> M.D. <u>3408 Rhode Island Ave</u> PHYSICIAN'S NAME (Type) <u>Leon R. Levitsky, MD</u> <u>Mt Rainier, Md</u> <u>Pr. Georges, Md</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/3/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Edgar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kalley's Funeral Home</u> <u>Inc.</u>				24a. REC'D BY REGISTRAR <u>MAY 4 '60</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

[Faint, illegible text, likely bleed-through from the reverse side of the page]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4904

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4858

1. PLACE OF DEATH o. COUNTY P rince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District Heights				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7306 Halleck Street				d. STREET ADDRESS 7306 Halleck Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Daniel Lucian Middle Isley Last Isley				4. DATE OF DEATH Month April Day 30 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 5, 1925	
9. AGE (In years last birthday) 34 yrs.		IF UNDER 1 YEAR Months 34 Days 34 Hours 34 Min. 34		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pressman				10b. KIND OF BUSINESS OR INDUSTRY Printing		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Henry D. Isley				14. MOTHER'S MAIDEN NAME Minnie Coble			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Alberta P. Isley Address 7306 Halleck Ave District Heights Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO (b) Shot gun wound of the head Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) Shot self with a shot gun							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self with a shot gun					
20c. TIME OF INJURY Month, Day, Year 2:15 p.m. 4/30/1960		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) District Heights P.G. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James I. Boyd				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF May 3, 1960		22c. NAME OF CEMETERY OR CREMATORY Arlington National	
22d. LOCATION (City, town, or county) (State) Arlington Va							
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home - Washington D.C.				ADDRESS Washington D.C.		24a. REC'D BY REGISTRAR DATE MAY 3 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

4843
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
64859

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sakoma Park		c. LENGTH OF STAY IN 1b years 53	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7009 Woodland Ave.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EMMA Middle SOPHIA Last JAMES		4. DATE OF DEATH Month April Day 26 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 9, 1869
9. AGE (In years lost birthday) 90 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Canby		14. MOTHER'S MAIDEN NAME Mary Hess	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Ruth J. Schayer (same as #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) anemia. fracture right pelvis. INTERVAL BETWEEN ONSET AND DEATH 2 days.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) fell in bedroom 20c. TIME OF INJURY Month, Day, Year Hour o. m. Mar. 24 1960 9:00 p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) State) (County) Takoma Park Montgomery, Md.			
21. I certify that (I) (this hospital) attended the deceased from May 1, 1956, to Apr. 26, 1960, that (I) (we) last saw the deceased alive on Apr. 25, 1960, and that death occurred at 7 AM, from the causes and on the date stated above.			
22a. SIGNATURE Samuel T. Hamble		22b. DATE SIGNED 26 Apr 60	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 929 Penning Drive, Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 29, 1960	
23c. NAME OF CEMETERY OR CREMATORY Greenhill Cemetery		23d. LOCATION (City, town, or county) State) Martinsburg, West Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters, 254 Carroll St NW DC		25a. REC'D BY REGISTRAR DATE APR 28 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kram			

1221

STATEMENT OF DEATH

1221

1221

1221

1221

1221

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4940

Reg. Dist. No. 4860

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland		c. LENGTH OF STAY IN 1b 3 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4718 Park Lane S.E.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 20 Suitland	
3. NAME OF DECEASED (Type or print) First Middle Last Stasys Jauniskis		4. DATE OF DEATH Month Day Year April 15, 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 29, 1898
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool Maker		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? Lithuania	
13. FATHER'S NAME Balys Jauniskis		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Elna Mazeika, same as no 2	
17. INFORMANT Address Elna Mazeika, same as no 2		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 974X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Due to Hanging DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Had cut both wrists		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Hanged self in basement of home		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour xxx 4/15/19 60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Suitland P. G. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 4/15/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-18-60	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers & Son		24a. REC'D BY REGISTRAR DATE APR 19 '60	
ADDRESS 577-11 E. D. SE.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

744

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

4837

4861

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>61 HYATTSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5802 41ST AVE.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLARA THERESA JOHNSON</u>		4. DATE OF DEATH Month Day Year <u>APRIL 18, 1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 11, 1871</u>
9. AGE (In years lost birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>THOMAS SHERWOOD</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET ARNOLD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO.</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS HELEN C FERGUSON</u> Address <u>5802 41st AVE</u> <u>DAUGHTER</u> <u>HYATTSVILLE, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral arterio-sclerosis</u> <u>442x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 1, 1959</u> to <u>April 15, 1960</u> , that I last saw the deceased alive on <u>April 15, 1960</u> , and that death occurred at <u>2:30</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clara T. Johnson</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>355 Myrtle Ave. W. 4/19/60</u>	
PHYSICIAN'S NAME (Type) <u>J. Chester Brady, M.D.</u>		<u>Washington 1 D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-22-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GLENWOOD CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co. Riverdale, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 21 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Clara T. Johnson</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

44x

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 23 Film G262 5/4/60 iwk

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs		c. LENGTH OF STAY IN 1b N/A	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hospital Andrews, AAFB, Md		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Newborn Middle Female Last Joyner		4. DATE OF DEATH Month April Day 24 Year 19 60	
5. SEX Female	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 24, 1960
9. AGE (In years last birthday) 1 yrs.		10. IF UNDER 1 YEAR Months 1 Days 56	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME John Britton Joyner		14. MOTHER'S MAIDEN NAME Ella Mae Skillman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. N/A	
17. INFORMANT MOTHER		Address Same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Premature birth DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 hr 56 Min	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr 24 , 19 60 , to Apr 24 , 19 60 , that I lost saw the deceased alive on April 24 , 19 60 , and that death occurred at 2:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED USAF Hospital Andrews, AAFB Md. 24 Apr 60			
ACTUAL SIGNATURE John A. Moore M.D. USAF Hospital Andrews, AAFB Md. 24 Apr 60			
PHYSICIAN'S NAME (Type) JOHN A. MOORE, Captain USAF, MC ANDREWS AFB, WASHINGTON 25, D. C.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE D.C.Morgue - 19th. & E St.S.E. Wash.D.C.		24a. REC'D BY REGISTRAR Apr 28 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Hanes			

2050304xv0

CENTRAL OF DEATH

1000 Hospital Avenue, APT. 100, NO.

Johnathan Lewis

Johnnie

April 30, 1900

Married

Miss Mary Sullivan

Johnnie

Married

Johnnie

1000 Hospital Avenue, APT. 100, NO.

John A. Smith, Captain, U.S. Army

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4863
4921 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georgez			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) University Park			c. LENGTH OF STAY IN 1b Md.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 64 University Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6506 40th Avenue				d. STREET ADDRESS 6506 40th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Russell Middle Wilmer Last Kirk				4. DATE OF DEATH Month April Day 27 Year 19 60			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-19-08		9. AGE (In years last birthday) 51 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor of personnell			10b. KIND OF BUSINESS OR INDUSTRY A.T.& T.		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Wilmer Kirk				14. MOTHER'S MAIDEN NAME Florence Cook			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Clara P. Kirk; same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c), stating the underlying cause last. DUE TO							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				DATE SIGNED April 27, 1960			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 30, 1960		22c. NAME OF CEMETERY OR CREMATORY Cherry Hill Cemetery		22d. LOCATION (City, town, or county) (State) Elkton Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.				24a. REC'D BY REGISTRAR MAY 2 1960		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4876

CERTIFICATE OF DEATH

4864
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 4 Wk.					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Franklin A. Kleindienst				4. DATE OF DEATH Month Day Year April 20 1960					
5. SEX Male		6. COLOR OR RACE W.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-21-86			
9. AGE (In years lost birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman - Stahl-meyer Meat Co.		10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.			
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph Kleindienst		14. MOTHER'S MAIDEN NAME Virginia Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 214-01-2524		INFORMANT Evelyn Brittain		Address same as above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mass in Gastric Intestinal Tract DUE TO Gastric intestinal Hemorrhage and Intestinal Polop. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cancer Of Right Upper Lobe of Lung. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from 1948 to April 1960 , that I last saw the deceased alive on April 20 1960 , and that death occurred at 8:55pm , from the causes and on the date stated above.					
ACTUAL SIGNATURE Benjamin A. Miller				ADDRESS (Street, city or town, state) 3824-34 St Mt Rainier DATE SIGNED 4-21-60					
PHYSICIAN'S NAME (Type) Dr. Miller Md.D.				3824-34 St. Mt Rainier, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/23/60		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.			
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home, Inc.				24a. REC'D BY REGISTRAR Mt. Rainier Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Hume			
DATE APR 25 '60									

1876

COMMUNICATIONS

U.S.A.

Washington, D.C.

Salomon - Stahl-meyer, Hans, no.

Virginia Unknown

Joseph Klingenstein

214-01-2524 Evelyn Brittain same as above

Local in Austria interesting item

Austria interesting item

1000

Amount of 1000 - 1000 of 1000

Washington, D.C.

M. Oliver, Secretary

1000 1000 1000

1000 1000 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital, or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4915

Item 2 Film G262 5/5/60 iwk

CERTIFICATE OF DEATH

Reg. Dist. No.

14865

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY PRINCE GEORGES					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIVERDALE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SAVAGE 13X-2					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LELAND MEMORIAL HOSP.				d. STREET ADDRESS					
3. NAME OF DECEASED (Type or print) First LOVELL Middle - Last KNISLEY				4. DATE OF DEATH Month APRIL Day 26 Year 1960					
5. SEX FE		6. COLOR OR RACE wh.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-2-93			
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAID-RETIRED				10b. KIND OF BUSINESS OR INDUSTRY					
11. BIRTHPLACE (State or foreign country) V.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Frank Fox				14. MOTHER'S MAIDEN NAME Laura Williams					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.					
17. INFORMANT JAMES T. KNISLEY-HUSBAND				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction - 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				(County)		(State)			
21. I certify that I attended the deceased from 4-26 , 19 60 , to 4-26 , 19 60 , that I last saw the deceased alive on 4-26 , 19 60 , and that death occurred at 9:35 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED									
ACTUAL SIGNATURE D.R. Purdie M.D.									
PHYSICIAN'S NAME (Type) D.R. PURDIE									
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)			
Burial		April 29, 1960		Madonridge Mausoleum		Prince Georges Md			
23. FUNERAL DIRECTOR'S SIGNATURE Donaldson				ADDRESS		24a. REC'D BY REGISTRAR DATE APR 29 '60			
24b. REGISTRAR'S SIGNATURE James T. Knisley									

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4942

CERTIFICATE OF DEATH

64866
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shirland</u>				c. LENGTH OF STAY IN 1b <u>6 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>21 Shirland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>30 Maryland Ave</u>				1d. STREET ADDRESS <u>30 Maryland Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>First</u> <u>EVITH.</u> <u>Middle</u> <u>EVELYN</u> <u>Last</u> <u>KUNTZ</u>				4. DATE OF DEATH <u>4-10</u> Month <u>19</u> Day <u>60</u> Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-4-1880</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Thomas Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry Kroger</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>450.0</u>		17. INFORMANT <u>Genevieve Kuntz</u>		Address <u>same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exhaustion Complication of Tumor</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour o. p. <u>11:30 p.m.</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1953</u> to <u>June 10, 1960</u> , that I last saw the deceased alive on <u>April 5, 1960</u> , and that death occurred at <u>4:50 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward A. Palank</u>				ADDRESS (Street, city or town, state) <u>52035-1000 NOLL RD SE GAITHERSBURG MD</u>			
PHYSICIAN'S NAME (Type) <u>EDWARD A PALANK</u>				DATE SIGNED <u>April 10/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>4-13-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wash. DC</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Mattingly</u>				ADDRESS <u>131-1182 Wash. DC</u>		24a. REC'D BY REGISTRAR <u>APR 12 60</u> DATE	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

CERTIFICATE OF DEATH

1962

458.0

<p>1. NAME OF DECEASED [Faint text, possibly "John Doe"]</p>		<p>2. SEX [Faint text, possibly "Male"]</p>	
<p>3. AGE [Faint text, possibly "65"]</p>		<p>4. DATE OF BIRTH [Faint text, possibly "10/15/1897"]</p>	
<p>5. PLACE OF BIRTH [Faint text, possibly "Baltimore, Md"]</p>		<p>6. RACE [Faint text, possibly "White"]</p>	
<p>7. OCCUPATION [Faint text, possibly "Teacher"]</p>		<p>8. CAUSE OF DEATH [Faint text, possibly "Heart Disease"]</p>	
<p>9. DATE OF DEATH [Faint text, possibly "11/1/1962"]</p>		<p>10. PLACE OF DEATH [Faint text, possibly "Home"]</p>	
<p>11. SIGNATURE OF PHYSICIAN [Faint signature]</p>		<p>12. SIGNATURE OF REGISTRAR [Faint signature]</p>	
<p>13. SIGNATURE OF WITNESS [Faint signature]</p>		<p>14. SIGNATURE OF DECEASED [Faint signature]</p>	

4877

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 1 Day d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly d. STREET ADDRESS 2903 56th Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>															
3. NAME OF DECEASED (Type or print) Harold V Lauth		4. DATE OF DEATH Month Apr. Day 16 Year 19 60		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 26. 1903		9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months 56		11. IF UNDER 24 HRS. Hours 56			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PERSONNEL OFFICER U.S. GOVT.				10b. KIND OF BUSINESS OR INDUSTRY U.S. GOVT.				11. BIRTHPLACE (State or foreign country) Montana				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Joseph A Lauth				14. MOTHER'S MAIDEN NAME Julie Sullivan				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) No				16. SOCIAL SECURITY NO. NONE				17. ADDRESS James H Lauth, 2808-63 Ave Chaverly Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Embolus, bifurcation of Aorta DUE TO 411X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Rheumatic Heart Disease DUE TO 10 yrs (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 36 hrs																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)																			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April 19 57 to Apr. 16 1960 , that I last saw the deceased alive on 4/16 19 60 , and that death occurred at 1:05 PM , from the causes and on the date stated above.																			
ACTUAL SIGNATURE Norman Donat Comeru M.D.				ADDRESS (Street, city or town, state) 3503 Penny St MT Rainier MD				DATE SIGNED 4/16/60											
PHYSICIAN'S NAME (Type) Norman Donat Comeru				22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 4-19-1960				22c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN				22d. LOCATION (City, town, or county) (State) WHEATON MD			
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers C ADDRESS 5801 Cleveland Ave				REC'D BY REGISTRAR APR 19 1960				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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4916

CERTIFICATE OF DEATH

Reg. Dist. No.

64868

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ma ryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b 5 Months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4809 Ravenswood Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ETHEL BURRHUES First Middle Last		4. DATE OF DEATH April 24 1960 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 3 1883
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Frederick C. Burrhuss		14. MOTHER'S MAIDEN NAME Flora Lynch	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none		16. SOCIAL SECURITY NO. none	
17. INFORMANT 4809 Ravenswood Road		18. MISS Jessie Burrhues, Riverdale, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of liver DUE TO Carcinoma left breast (primary site) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 mos + 2 yrs. +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 18, 1958 to April 24, 1960 , that I last saw the deceased alive on April 18, 1960 , and that death occurred at 10:35 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Arnold McNitt		ADDRESS (Street, city or town, state) 1835 Eye St., N.W., Washington, D.C.	
PHYSICIAN'S NAME (Type) Arnold McNitt		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/27/60	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suirtland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home		ADDRESS 398-4 St. N.E. WASH, D.C.	
24a. REC'D BY REGISTRAR DATE APR 27 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1916

Plase George No Tynd Plase George

Riverdale 2 Months Riverdale

1809 Ravenswood Road 1809 Ravenswood Road

Female White BURNING LEE April 22 1960

House Wife Nov 3 1939 76

Washington, D.C. U.S.A.

Frederick C. Burnham Phone Lynch 1809 Ravenswood Road

none none none Miss Jessie Burnham Riverdale, Md

CERTIFICATE OF DEATH

Reg. Dist. No.

4838

4869

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>California</u> c. COUNTY <u>Sacramento</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				c. LENGTH OF STAY IN 1b <u>2 Months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5610 Decatur Place</u>				d. STREET ADDRESS <u>2815 Eye St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Lillian</u> First <u>Florence</u> Middle <u>Marecron</u> Last				4. DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 3, 1877</u>	
9. AGE (In years lost birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>83</u> Days <u>83</u> Hours <u>83</u> Min.		IF UNDER 24 HRS. Months <u>83</u> Days <u>83</u> Hours <u>83</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>James Watson</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Edelen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Charles Kidwell</u>				Address <u>5610 Decatur Place</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia</u> DUE TO <u>153.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Metastatic Carcinoma</u> DUE TO <u>Carcinoma of Cecum and Uterus</u> (c) <u>Nov. 1959</u> <u>Nov. 1958</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb</u> , 19 <u>60</u> , to <u>April</u> , 19 <u>60</u> that I last saw the deceased alive on <u>April 19</u> , 19 <u>60</u> , and that death occurred at <u>7:52 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thos. M. Hutchins</u>				ADDRESS (Street, city or town, state) <u>7315 Landonover Rd. Hyattsville Md 4/19/60</u>			
PHYSICIAN'S NAME (Type) <u>Thos. M. HUTCHINS</u>				DATE SIGNED <u>4/19/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/22/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Halley's Funeral Home Inc.</u>				ADDRESS <u>Mt. Rainier Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 25 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Orlando S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1832

CERTIFICATE OF DEATH

State of New York
County of Albany
I, the undersigned, Clerk of the County of Albany, do hereby certify that on the 11th day of November, 1832, at the City of Albany, in the County of Albany, State of New York, died *John A. Smith*, of the County of Albany, State of New York, in the 45th year of his age, and that he was buried in the *Albany* Burial Ground, in the City of Albany, in the County of Albany, State of New York, on the 12th day of November, 1832.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4845

Items 8, 9 Film G264 6-8-60 et

Reg. Dist. No.

64870

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg		c. LENGTH OF STAY IN 1b 12 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5507 Landover Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 42 Cheverly	
d. STREET ADDRESS 3110 Lake Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Emmett Spurgeon Mast		4. DATE OF DEATH Month Day Year April 7, 1960	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-16-01 1905
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate		10b. KIND OF BUSINESS OR INDUSTRY Real Estate	
11. BIRTHPLACE (State or foreign country) Tenn.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel Baker Mast		14. MOTHER'S MAIDEN NAME Maude Walker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. 2	
17. INFORMATION Address Bernice R. Mast; same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO 976X Conditions, if any, which gave rise to immediate cause (b) Cerebral laceration (c) Gunshot wound of head DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted gunshot wound of head.	
20c. TIME OF INJURY Month, Day, Year Hour Min. 4-7-60 19		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Office		20f. (City or town) Bladensburg (County) Pr. Geo. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 7, 1960	
22a. BURIAL, CREMATION, or other disposition (Specify) Burial		22b. DATE THEREOF 4/12/60	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) Arlington, Va. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland	
24a. REC'D BY REGISTRAR DATE APR 11 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES W. WILSON		45		Male		White		1918		Home	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY		POST-MORTEM	
1234 Main St.		Teacher		Heart Disease		Natural		None		None	
BIRTH		DEATH		TEMP.		PULSE		BLOOD		URINE	
1873		1918		98.6		72		Normal		Normal	
FATHER		MOTHER		SIBLINGS		PREVIOUS ILLNESS		TREATMENT		BURIAL	
John W. Wilson		Mary E. Wilson		None		None		None		Buried	
CITY		COUNTY		STATE		COUNTRY		CITY		COUNTY	
Baltimore		Baltimore		Maryland		United States		Baltimore		Baltimore	
CITY		COUNTY		STATE		COUNTRY		CITY		COUNTY	
Baltimore		Baltimore		Maryland		United States		Baltimore		Baltimore	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG261 4-18-60 et

4917

CERTIFICATE OF DEATH

Reg. Dist. No.

64871

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>36 Brentwood</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Beland Memorial Hosp.</u>				d. STREET ADDRESS <u>3605 Tilden St</u>			
3. NAME OF DECEASED (Type or print) First <u>SARAH</u> Middle <u>Virginia</u> Last <u>May</u>				4. DATE OF DEATH Month <u>April</u> Day <u>11</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 10 - 1861</u>	
9. AGE (In years last birthday) <u>98</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Jesse Chinn</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Rowe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Record</u> Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of Transverse Colon</u> <u>153.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with Abscess & Fistula into Duodenum</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> <u>9 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Cardiovascular Disease</u> <u>10 years</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month _____ Day _____ Year <u>19</u> Hour <u>a. p.</u> p. m. _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
				20f. (City or town) _____		(County) _____ (State) _____	
21. I certify that I attended the deceased from <u>August 21, 1956</u> to <u>April 11, 1960</u> , that I last saw the deceased alive on <u>April 10, 1960</u> , and that death occurred at <u>6:10 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walcutt W. Gibson</u>				ADDRESS (Street, city or town, state) <u>2412 Minnesota Ave. S.E.</u>			
PHYSICIAN'S NAME (Type) <u>Walcutt W. Gibson</u>				DATE SIGNED <u>Washington 20, D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/14/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>P. G. Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert C. Vincent</u>				ADDRESS <u>2525 Bladensburg Rd. N.E. Wash.</u>		24c. REC'D BY REGISTRAR <u>D. CAPR 13 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4905

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

04872

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Neibert Heights</u>		c. LENGTH OF STAY IN 1b <u>6 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7119 Alpine Street</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>231 Neibert Heights</u>	
3. NAME OF DECEASED (Type or print) <u>Herman</u> First <u>Murray</u> Middle <u>Meeks</u> Last		4. DATE OF DEATH <u>April 13</u> Month <u>13</u> Day <u>1960</u> Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 4, 1921</u>
9. AGE (In years last birthday) <u>38</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Herman Murray Meeks</u>		14. MOTHER'S MAIDEN NAME <u>Mattie Rebecca Schwindel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>577-18-6149</u>	
17. INFORMANT <u>Mr. Georgiana Meeks, same as #</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>James I. Boyd</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>April 15, 1960</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-16-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sammons Bros.</u> ADDRESS <u>1661-Conn Hope Rd SE WASH. 20 DC</u>		24a. REC'D BY REGISTRAR DATE <u>APR 18 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

NEW YORK STATE DEPARTMENT OF HEALTH - BALTIC 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

428.1

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. OCCUPATION		6. DATE OF DEATH	
7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. SIGNATURE OF EXAMINER		11. SIGNATURE OF WITNESS		12. SIGNATURE OF CORONER	
13. SIGNATURE OF JURY		14. SIGNATURE OF JURY		15. SIGNATURE OF JURY	
16. SIGNATURE OF JURY		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY	
19. SIGNATURE OF JURY		20. SIGNATURE OF JURY		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
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40. SIGNATURE OF JURY		41. SIGNATURE OF JURY		42. SIGNATURE OF JURY	
43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY	
49. SIGNATURE OF JURY		50. SIGNATURE OF JURY		51. SIGNATURE OF JURY	
52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY	
55. SIGNATURE OF JURY		56. SIGNATURE OF JURY		57. SIGNATURE OF JURY	
58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
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91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY	
94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

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r. Page
files
Health,

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is not required, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. **TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. Page 4 should be retained for your records. Page 5 should be retained for your records. **TO THE STATE BOARD OF HEALTH:** This certificate should be forwarded to the State Board of Health, within 72 hours after death, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY		c. LENGTH OF STAY IN 1b D.O.A		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER HILL		d. STREET ADDRESS 4751 BRANCH AVE			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PRINCE GEORGES GEN. HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) HENRI First JEAN Middle MILETTE Last				4. DATE OF DEATH Month APRIL Day 12 Year 1960					
5. SEX MALE		6. COLOR OR RACE CAU		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 26, 1893			
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY WASH. PETROLEUM PRODUCTS		11. BIRTHPLACE (State or foreign country) MONTREAL, CANADA		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME MARC HENRI MILETTE				14. MOTHER'S MAIDEN NAME MARIE LOUISE RATEL					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. YES 225-05-0829		17. INFORMANT MRS. JACQUELINE MITCHELL Address JESSUP, MD.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 451X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Ruptured abdominal aortic aneurysm DUE TO (c) aortic atherosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/>								INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19 <input type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 4-13-60 Address (Street, city, town, or county) upper marlboro, Md									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 16-60		22c. NAME OF CEMETERY OR CREMATORY Trinity Cemetery		22d. LOCATION (City, town, or county) (State) upper marlboro, Md			
23. FUNERAL DIRECTOR Simmons Bros		ADDRESS 1661 Good Hope Rd		24a. REC'D BY REGISTRAR DATE APR 18 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Harris			

4504

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4943 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>VA.</u> b. COUNTY <u>83X-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Adelphi</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Saint Branch Nursing Home</u>		d. STREET ADDRESS <u>2604 Key Blvd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Herbert</u> Middle <u>Russell</u> Last <u>Mills</u>		4. DATE OF DEATH Month <u>April</u> Day <u>18</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 27, 1898</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerical</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>County Govt. Worker</u>	9. AGE (in years last birthday) <u>81</u> yrs.
13. FATHER'S NAME <u>Thomas Mills</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
16. SOCIAL SECURITY NO. <u>226-46-9749</u>		17. INFORMANT <u>Nursing Home Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 20, 1959</u> to <u>April 18, 1960</u> , that I last saw the deceased alive on <u>Apr-18, 1960</u> , and that death occurred at <u>2:25 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jane M. O'Brien</u> M.D.		ADDRESS (Street, city or town, state) <u>2717 Carroll Ave</u> DATE SIGNED <u>4-18-60</u>	
PHYSICIAN'S NAME (Type) <u>Takoma Pauls MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>transportation</u>	22b. DATE THEREOF <u>4-20-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Buena Vista, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. Funeral Home</u>		ADDRESS <u>Arlington, Virginia</u>	
24a. REC'D BY REGISTRAR <u>DATE APR 22 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Knead</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4879

CERTIFICATE OF DEATH

Reg. Dist. No.

64875

1. PLACE OF DEATH a. COUNTY Prince George				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 40 min.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berwyn				d. STREET ADDRESS 4809 Greenbelt Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) Baby boy Moltz				4. DATE OF DEATH Month April Day 23 Year 1960				5. SEX Male				6. COLOR OR RACE White				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH April 23, 1960				9. AGE (In years last birthday) yrs. 10				10. IF UNDER 1 YEAR Months 10				11. IF UNDER 24 HRS. Days 10				12. IF UNDER 10 HRS. Hours 10				13. IF UNDER 1 MIN. Min. 10			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME George Edward Moltz				14. MOTHER'S MAIDEN NAME Peggy Ann Sturgess				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 1				17. INFORMANT Mother				18. Address Same							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) AN RNCephelic Monte DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____				INTERVAL BETWEEN ONSET AND DEATH				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) _____ (County) _____ (State) _____											
21. I certify that I attended the deceased from Apr. 23 , 19 60 , to Apr. 23 , 19 60 , that I last saw the deceased alive on Apr. 23 , 19 60 , and that death occurred at 1:30 PM from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 1801 Eye Street, N.W.				DATE SIGNED Dr. Fuad I. Kaibni, M.D.				ACTUAL SIGNATURE Dr. Fuad I. Kaibni, M.D.				PHYSICIAN'S NAME (Type) Dr. Fuad I. Kaibni, M.D.				22a. BURIAL, CREMATION, REMOVAL (Specify) cremation				22b. DATE THEREOF 4/26/60				22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly, Md.				22d. LOCATION (City, town, or county) _____ (State) _____											
23. FUNERAL DIRECTOR'S SIGNATURE Harry W Penn, Jr.				24a. REC'D BY REGISTRAR DATE APR 28 '60				24b. REGISTRAR'S SIGNATURE Charles L. Thomas				25. SIGNATURE OF REGISTRAR Charles L. Thomas				26. SIGNATURE OF REGISTRAR Charles L. Thomas				27. SIGNATURE OF REGISTRAR Charles L. Thomas																							

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155

13-12-61 Gladys County, Oregon
14-12-61 Gladys County, Oregon

Reg. Dist. No.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 1 yr., and 29 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		d. STREET ADDRESS 4 Logan Circle, N. W.	
3. NAME OF DECEASED (Type or print) First James Middle - Last Morgan		4. DATE OF DEATH Month 4 Day 14 Year 19 60	
5. SEX Male		6. COLOR OR RACE Colored	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/15/13	
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months - Days - Hours - Min. -	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanics Helper		10b. KIND OF BUSINESS OR INDUSTRY Corps of Engineering	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Morgan		14. MOTHER'S MAIDEN NAME Ella Bean	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Post-operative pulmonary hemorrhage 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b): Right upper lobectomy DUE TO (c): PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Pulmonary tuberculosis		INTERVAL BETWEEN ONSET AND DEATH 20 minutes 8 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/16/19 59 , to 4/14/19 60 that I last saw the deceased alive on 4/14/19 60 , and that death occurred at 4:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Glenn Dale Hospital DATE SIGNED 4/14/60 ACTUAL SIGNATURE Moe Weiss M.D. Glenn Dale, Md. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) 4-18-60		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Pfwoth Funeral Home, Inc. 814-Opshurst, N.W.		24a. REC'D BY REGISTRAR DATE APR 18 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

LSM A15 (4)
15M 9/5B

783.1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4880

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

04878

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 69 College Park			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 9501 50th Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alice Middle Viola Last Mothershead				4. DATE OF DEATH Month April Day 15 Year 19 60			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-21-10	9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Administrative assistant		10b. KIND OF BUSINESS OR INDUSTRY Dept of Commerce		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles J. Feighenne				14. MOTHER'S MAIDEN NAME Augusta Stonosky			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Andrew A. Mothershead ; same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral and pulmonary edema DUE TO Cardiac dilatation Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO Cirrhosis of liver (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED April 15, 1960	
EXAMINER'S NAME (Type) John T. Maloney, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/19/60	22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.				24a. REC'D BY REGISTRAR DATE APR 21 '60		24b. REGISTRAR'S SIGNATURE William S. Frank	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4907

CERTIFICATE OF DEATH

64879

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairmount Heights</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Fairmount Heights</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1019-58" Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Cash</u> Middle <u>Delaney</u> Last <u>Murphy</u>		4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 25, 1890</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Moths Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Bristow, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Murphy</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Hall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-16-3647</u>	
17. INFORMANT <u>Dorothy Byrnn</u> Address <u>1019-58" Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio-Vas. Disease</u> DUE TO (c) <u>unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-4-7</u> , 19 <u>60</u> , to <u>4-13</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4-12</u> , 19 <u>60</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John W. Robinson</u> M.D.		DATE SIGNED <u>1001 Eastern Ave. N.E. 4/13/60</u>	
PHYSICIAN'S NAME (Type) <u>John W. Robinson, M.D.</u>		<u>Washington 27, D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-17-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Murphy Family</u>		22d. LOCATION (City, town, or county) (State) <u>Bristow, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Myrtle R. Rollins</u> ADDRESS <u>4339 Hunt Pl. N.E.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 18 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Charles E. Kneass</u>	

CERTIFICATE OF DEATH

442x

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	
JAMES EARL RAY		M		35		W		1928		MEMPHIS, TENN.		APR 4, 1968		MEMPHIS, TENN.		HEART DISEASE		NATURAL		JAMES EARL RAY		JAMES EARL RAY	
13. OCCUPATION		14. EDUCATION		15. MARITAL STATUS		16. RELIGION		17. PREVIOUS ILLNESS		18. PREVIOUS SURGERY		19. PREVIOUS TRAUMA		20. PREVIOUS DRUGS		21. PREVIOUS ALCOHOL		22. PREVIOUS TOBACCO		23. PREVIOUS OTHER		24. PREVIOUS OTHER	
ATTORNEY		HIGH SCHOOL		MARRIED		METHODIST		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS		31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS		34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

442x

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4946

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE -- b. COUNTY --	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suitland Nursing Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
3. NAME OF DECEASED (Type or print) First ROSELLA Middle NABORS Last NABORS		4. DATE OF DEATH Month April Day 16 Year 19 60	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 1, 1883	
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 4 Days 16 Hours 3 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk-U.S. Tres. Dep't.		10b. KIND OF BUSINESS OR INDUSTRY Michigan	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ----- Malansing		14. MOTHER'S MAIDEN NAME ----- Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWT		16. SOCIAL SECURITY NO. None	
17. INFORMANT Blake E. Nabors-1817 18th. St., SE DC20		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CEREBRAL THROMBOSIS DUE TO (c) GENERALIZED ARTERIOSCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH 4 days 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-15-46 , 19____, to 4-16-60 , 19____, that I last saw the deceased alive on 4-15-60 , 19____, and that death occurred at 4:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John B. Ryan		M.D. 2210 NICHOLS AVE S.E.	
PHYSICIAN'S NAME (Type) JOHN B. RYAN, M.D.		WASH., D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-18-60	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE James T. Ryan, Inc.		ADDRESS 317 Pa. Ave., SE	
24a. REC'D BY REGISTRAR APR 18 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

420.1

NAME OF DECEASED JAMES T. YOUNG, JR.		SEX Male		AGE 42 years	
DATE OF DEATH April 1, 1941		PLACE OF DEATH Baltimore, Md.		TIME OF DEATH 10:30 A.M.	
CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural		PLACE OF BIRTH Baltimore, Md.	
OCCASION OF DEATH Sudden		PREVIOUS ILLNESS None		OCCUPATION Engineer	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES (None)		SIGNATURE OF PHYSICIAN (None)	
SIGNATURE OF REGISTRAR (None)		SIGNATURE OF CLERK (None)		SIGNATURE OF JURY (None)	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT, BALTIMORE, MARYLAND.

CERTIFICATE OF DEATH

4881
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 10 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH Month April Day 2 Year 1960				5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 16 July 1879 9. AGE (In years lost birthday) 80 IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY County Police			
11. BIRTHPLACE (State or foreign country) Washington D. C.				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME George Norgle				14. MOTHER'S MAIDEN NAME Mary Lechlitter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic Heart disease DUE TO (c) old C.V.A.				INTERVAL BETWEEN ONSET AND DEATH 3-29-60			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 3-23 , 1960, to 4-2 , 1960, that I last saw the deceased alive on 4-2 , 1960, and that death occurred at 1:20 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE George Heage				ADDRESS (Street, city, or town, state) 3717-38th Ave DATE SIGNED 4-2-60			
PHYSICIAN'S NAME (Type) Dr. G. Heage, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 5, 1960		22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		22d. LOCATION (City, town, or county) (State) Bladensburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Md.				24a. REC'D BY REGISTRAR APR 5 '60 DATE		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1931

Private Justice

Private Justice

Private Justice

Private Justice

Private Justice

Private Justice

Private Justice

Private Justice

Private Justice

Private Justice

Private Justice

Private Justice

Private Justice

Private Justice

Private Justice

Private Justice

181

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4948

Item 22 Film G261 4/25/60 cap

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (Rural)		c. LENGTH OF STAY IN 1b 2 mo., 14 das.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Herbert Middle - Last Ollerenshaw		4. DATE OF DEATH Month April Day 15 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb. 19, 1916
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months 4 Days 14 Hours 14 Min.	11. IF UNDER 24 HRS. Hours 14 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Apt. Bldg.	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James J. Ollerenshaw		14. MOTHER'S MAIDEN NAME Lillie Hardley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 579-03-4768	
17. INFORMANT Person		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Pulmonary hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Far Advanced Pulmonary Tuberculosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH 10 min. 9 mo.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 1 , 19 60 , to Apr. 15 , 19 60 , that I last saw the deceased alive on Apr. 15 , 19 60 , and that death occurred at 7:20 P M, from the causes and on the date stated above.		DATE SIGNED Apr. 15, 1960	
ACTUAL SIGNATURE Moe Weiss		M.D. Glenn Dale Hospital	
PHYSICIAN'S NAME (Type) Moe Weiss M.D.		Glenn Dale, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) 4-14-1960		22b. DATE THEREOF 4-14-1960	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE R. G. Mattering 131-11th St. SE. D.C. George Kalas 660		24a. REC'D BY REGISTRAR APR 19 1960	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

STATEMENT OF DEATH

1942

Decedent's Name: [Illegible] [Illegible] [Illegible]

Date of Death: [Illegible] [Illegible] [Illegible]

Place of Birth: [Illegible] [Illegible] [Illegible]

Place of Death: [Illegible] [Illegible] [Illegible]

Age at Death: [Illegible] [Illegible] [Illegible]

Sex: [Illegible] [Illegible] [Illegible]

Marital Status: [Illegible] [Illegible] [Illegible]

Occupation: [Illegible] [Illegible] [Illegible]

Education: [Illegible] [Illegible] [Illegible]

Religion: [Illegible] [Illegible] [Illegible]

Signature of Physician: [Illegible] [Illegible] [Illegible]

Signature of Registrar: [Illegible] [Illegible] [Illegible]

Signature of Coroner: [Illegible] [Illegible] [Illegible]

Signature of Medical Examiner: [Illegible] [Illegible] [Illegible]

Signature of [Illegible]: [Illegible] [Illegible] [Illegible]

Signature of [Illegible]: [Illegible] [Illegible] [Illegible]

Signature of [Illegible]: [Illegible] [Illegible] [Illegible]

Signature of [Illegible]: [Illegible] [Illegible] [Illegible]

Signature of [Illegible]: [Illegible] [Illegible] [Illegible]

Signature of [Illegible]: [Illegible] [Illegible] [Illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

64884

4847

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Capitol Heights</u>		c. LENGTH OF STAY IN 1b <u>10 year</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>30 Capitol Heights</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>612-59th Avenue</u>				1d. STREET ADDRESS <u>612-59th Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harold Crawford Page</u>				4. DATE OF DEATH Month Day Year <u>April 18 1960</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 6, 1900</u>		9. AGE (In years last birthday) <u>60 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shoe maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Allen Page</u>				14. MOTHER'S MAIDEN NAME <u>Morning Price</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>192-151923-577-05-0160</u>		17. INFORMANT Address <u>Mrs. Genevieve Page same as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cardiovascular renal disease</u> (c) <u>Cardiovascular renal disease</u> DUE TO cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>April 18, 1960</u>			
22a. BURIAL CREMATION (REMOVAL) (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/22/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAACON</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Jr - 577-1195</u> <u>WASH. D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 22 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneass</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4882

CERTIFICATE OF DEATH

4885

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 4009 Newton Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Howard Middle S. Last Pearson				4. DATE OF DEATH Month April Day 13 Year 1960			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 18, 1898	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY C&P Tel. Co.		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry B. Pearson				14. MOTHER'S MAIDEN NAME Molly Strother			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) WW 1 577-01-1229		17. INFORMANT Pearl Pearson Address 4009 Newton St. Colmar Manor, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral metastasis 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) BRONCHOGENIC CARCINOMA DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 month 7 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. City or town	(County)	(State)	
21. I certify that I attended the deceased from August 1959 to March 13, 1960 , that I last saw the deceased alive on March 13, 1960 , and that death occurred at 2:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3408 Rhode Island Ave. DATE SIGNED 4/13/60 ACTUAL SIGNATURE Leon R. Levitsky M.D. PHYSICIAN'S NAME (Type) Leon R. Levitsky, M. D. Mt. Rainier, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/18/60	22c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. ADDRESS -2901 14th St. N.W. Washington 9, D.C.				24a. REC'D BY REGISTRAR DATE APR 18 '60		24b. REGISTRAR'S SIGNATURE Charles E. Harris	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

1621

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4906

CERTIFICATE OF DEATH

64886
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District Heights				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 24 District Heights			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5513- Parkland Court				d. STREET ADDRESS 5513- Parkland Court			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) TERESA First Middle Last PELAGATTI				4. DATE OF DEATH April 21st. Month Day Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 21st 1881	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Peter DiDiego				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Renato Pelagatti Same as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart disease DUE TO (c) 7 years.							INTERVAL BETWEEN ONSET AND DEATH 2 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March , 19 53 , to April 22 , 19 60 , that I last saw the deceased alive on 4-22- 19 60 , and that death occurred at 11:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5731-23rd Parkway SE DATE SIGNED 4-22-60 ACTUAL SIGNATURE David S. Gordon M.D. David S. Gordon PHYSICIAN'S NAME (Type) DAVID S. GORDON Wash. D.C.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 23-60		22c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		22d. LOCATION (City, town, or county) (State) Yeadon, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Brothers ADDRESS 1661- Good Hope Road S.E.				24a. REC'D BY REGISTRAR DATE APR 25 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4883

CERTIFICATE OF DEATH

Reg. Dist. No.

64887

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 da.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle W. Last Penn		4. DATE OF DEATH Month April Day 20 Year 19 60	
5. SEX Male	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30 June 1876
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Tobacco	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John W. Penn		14. MOTHER'S MAIDEN NAME Henerietta Pickeral	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219 34 7991	
17. INFORMANT Nellie H. Penn		Address Same as # 2 (Wife)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Nephrosclerosis due to arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO Carcinoma of Prostate (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr. 19 , 19 60 , to Apr. 19 , 19 60 that I last saw the deceased alive on Apr. 19 , 19 60 , and that death occurred at 5:10pm from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3824 34th St. DATE SIGNED ACTUAL SIGNATURE Benjamin S. Miller M.D. PHYSICIAN'S NAME (Type) Dr. Benjamin S. Miller, M.D. Mt Rainier, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/23/60	
22c. NAME OF CEMETERY OR CREMATORY Union Cemetery		22d. LOCATION (City, town, or county) (State) Alex. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR APR 27 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4884 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

64868

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 43 Bladensburg		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 3400 Kenilworth Avenue			
3. NAME OF DECEASED (Type or print) First Lewis Middle Perkins Last Perkins				4. DATE OF DEATH Month April Day 9 Year 19 60			
5. SEX Male	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-3-01		9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Utility man		10b. KIND OF BUSINESS OR INDUSTRY Automobile		11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-10-0681		17. INFORMANT Myrtle K. Rollins; 4339 Hunt Pl., N.E. Washington, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c) Cardiovascular renal disease DUE TO (c) Cardiovascular renal disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 9, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-13-60		22c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial		22d. LOCATION (City, town, or county) (State) Suitland md.	
23. FUNERAL DIRECTOR'S SIGNATURE Myrtle K. Rollins				ADDRESS 4339 Hunt Pl., N.E.		24a. REC'D BY REGISTRAR DATE APR 13 '60	
						24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

442X

STATE OF NEW YORK
DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]
2. SEX: [illegible]
3. AGE: [illegible]
4. DATE OF BIRTH: [illegible]
5. PLACE OF BIRTH: [illegible]
6. OCCUPATION: [illegible]
7. CAUSE OF DEATH: [illegible]
8. MANNER OF DEATH: [illegible]
9. SIGNATURE OF MEDICAL EXAMINER: [illegible]
10. DATE: [illegible]

may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4844
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

64889

1. PLACE OF DEATH a. COUNTY <u>Prince Georges County</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P. G.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 Jakoma Park</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>467 Beech Avenue</u>			d. STREET ADDRESS <u>1 467 Beech Avenue</u>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>ELLSWORTH</u> Middle <u>-</u> Last <u>PHELPS</u>			4. DATE OF DEATH Month <u>Apr.</u> Day <u>25</u> Year <u>1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 13, 1891</u>		9. AGE (In years last birthday) <u>68</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Adm. Officer - Div. of Standards Federal Govt.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Connecticut</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>William Phelps</u>			14. MOTHER'S MAIDEN NAME <u>Marian Ellsworth</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>-</u>		
17. INFORMANT <u>Mrs Barbara Secret</u> Address <u>Beech Ave. Jak. Pr. Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last, (b) <u>-</u> DUE TO (c) <u>-</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <u>Apr. 23</u> 19 <u>60</u> , to <u>25</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>23 Apr. 1960</u> , and that death occurred at <u>9:45</u> A.M., from the causes and on the date stated above.					
22a. SIGNATURE <u>M. B. Queen</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>25 Apr 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>M. B. QUEEN</u>		22d. ADDRESS <u>7112 Willow Ave Takoma Park, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>April 27, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	23d. LOCATION (City, town, or county) <u>Prince Georges Co Md.</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>		ADDRESS <u>254 Carroll St NW. D.C.</u>		25a. REC'D BY REGISTRAR <u>Arthur E. Evans</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur E. Evans</u>

U.S. DEPARTMENT OF HEALTH
BUREAU OF VETERINARY MEDICINE
WASHINGTON, D. C.

1944

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(1)

U.S. DEPARTMENT OF HEALTH
BUREAU OF VETERINARY MEDICINE
WASHINGTON, D. C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4909 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 4890

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 121 2nd Street				d. STREET ADDRESS 121 2nd Street			
3. NAME OF DECEASED (Type or print) First Francis Middle Potter Last Potter				4. DATE OF DEATH Month April Day 1 Year 19 60			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb 9, 1894		9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chef		10b. KIND OF BUSINESS OR INDUSTRY Diner		11. BIRTHPLACE (State or foreign country) Philadelphia Pa		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Thomas F Potter				14. MOTHER'S MAIDEN NAME Catherine Mannion			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 578 12 7223		17. INFORMANT Minnie Z Potter Meridan Connecticut.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Defuse Bronchopneumonia DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		April 2, 1960	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/4/60		22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Maryland				24a. REC'D BY REGISTRAR DATE APR 6 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hearn	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		SEX [REDACTED]	
AGE [REDACTED]		RACE [REDACTED]	
DATE OF BIRTH [REDACTED]		PLACE OF BIRTH [REDACTED]	
DATE OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]	
TIME OF DEATH [REDACTED]		CAUSE OF DEATH [REDACTED]	
MANNER OF DEATH [REDACTED]		SIGNATURE OF MEDICAL EXAMINER [REDACTED]	
SIGNATURE OF REGISTRAR [REDACTED]		OFFICIAL SEAL [REDACTED]	

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

4/27/60
mnb

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4839
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

4891

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b 37 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 60 Hyattsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5631 Jamestown Road		d. STREET ADDRESS 5631 Jamestown Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Harry Middle W. Last Price		4. DATE OF DEATH Month April Day 11 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 1, 1885
9. AGE (In years last birthday) 74		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Kansas City, Missouri,		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry N. Price		14. MOTHER'S MAIDEN NAME Elizabeth Walker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Harry W. Price, 5631 Jamestown Rd., Hyattsville, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Myocardial insufficiency DUE TO X (b) Saccular Atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-4 1960, to 11-11 1960, that (I) (we) last saw the deceased alive on 4-16 1960, and that death occurred at M, from the causes and on the date stated above.			
22a. SIGNATURE X Aaron Deitz M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 4314 Gallatin St., Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/13/1960	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Bladensburg, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers, Riverdale, Md.		25a. REC'D BY REGISTRAR MAY 2 '60	
		25b. REGISTRAR'S SIGNATURE	

1938

WARRANT FOR ARREST OF DEBTOR

CERTIFICATE OF DEBT

1938

Debtor's Name	John J. Smith
Address	123 Main Street, New York, N.Y.
Amount Owed	\$100.00
Due Date	Jan. 1, 1938
Signature of Creditor	John J. Smith
Signature of Debtor	John J. Smith
Witness	John J. Smith

X
X

1938

X

Warrant for Arrest of Debtor
This warrant is issued by the Court of Sessions of the City and County of New York, in and for the Southern District of New York, in the matter of John J. Smith, Debtor, against the said John J. Smith, for the non-payment of a debt of \$100.00, due and payable on the 1st day of January, 1938, to the said John J. Smith, as evidenced by a certificate of debt filed in the office of the Clerk of the Court of Sessions of the City and County of New York, in and for the Southern District of New York, on the 1st day of January, 1938.

4885

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 5 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 66 E. Riverdale, d. STREET ADDRESS 5517 Nicholson St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Dora		First Rappaport		Last Apr.		4. DATE OF DEATH Month 17 Day 19 Year 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 1871	9. AGE (In years lost birthday) 88 yrs.	IF UNDER 1 YEAR Months 88	IF UNDER 24 HRS. Days 88	Hours 88 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Hershel Weiner				14. MOTHER'S MAIDEN NAME Roda Finkelstein			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Mrs. Rose Norry Daughter, Same Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Thrombosis DUE TO (c) Arteriosclerotic Heart Disease				INTERVAL BETWEEN ONSET AND DEATH 24 hours 5 days ??			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 12, 1960 to Apr. 17, 1960 that I last saw the deceased alive on April 16, 1960 , and that death occurred at 10:40 AM from the causes and on the date stated above.							
ACTUAL SIGNATURE David S. Clayman				ADDRESS (Street, city or town, state) 6311 Baltimore, Ave. Riverdale, Md.			
PHYSICIAN'S NAME (Type) Dr. David S. Clayman, M.D.				DATE SIGNED 4-17-60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-19-60		22c. NAME OF CEMETERY OR CREMATORY Agudas Achim Cem.		22d. LOCATION (City, town, or county) (State) Rochester, N.Y.	
23. FUNERAL DIRECTOR'S SIGNATURE Herbert				ADDRESS 4217 9th Street N.W.		24a. REC'D BY REGISTRAR DATE APR 19 1960	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

64893

4918

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b 58 Hyattsville, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Leland Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Florence Salome Reed		4. DATE OF DEATH Month Day Year April 18, 19 60	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 16, 1892
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Aaron Heitzman		14. MOTHER'S MAIDEN NAME Eva Sandt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Lilah Thomas Hyattsville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Arterio sclerosis Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) cerebral Hemorrhage INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 4/18		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/18, 1957, to 4/18, 1960, that I last saw the deceased alive on 4/18, 1960, and that death occurred at 6:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE A K BOWIE		ADDRESS (Street, city or town, state) 301 Constitution E Wash DC	
DATE SIGNED 4/17/60			
PHYSICIAN'S NAME (Type) A K BOWIE			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/21/60	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Maryland.	
24a. REC'D BY REGISTRAR DATE APR 21 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4896

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 20 Film G260 4/11/60 jwk

Reg. Dist. No.

4895

1. PLACE OF DEATH a. COUNTY prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 24	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Kingsley Middle George Last Richardson		4. DATE OF DEATH Month April Day 6 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 24, 1910
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months 4 Days 9	IF UNDER 24 HRS. Hours 1 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Ceder Hill Cemetary Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Claude Richardson		14. MOTHER'S MAIDEN NAME Boxie Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Mrs. Margaret R. Richardson Same as # 2.	
17. INFORMANT Mrs. Margaret R. Richardson		Address Same as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonitis 916.5 DUE TO Conditions, if any, which gave rise to immediate cause (b) Third degree burns of the legs (c) Due to (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Clothes caught on fire while he was putting out a fire	
20c. TIME OF INJURY Month, Day, Year 8:10 PM 4/29/60	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	20f. (City or town) (County) (State) Suitland P. G. Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		DATE SIGNED 4-6-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 9-60	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Suitland, Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros		24a. REC'D BY REGISTRAR APR 7 '60	24b. REGISTRAR'S SIGNATURE Arthur L. Hines

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in duplicate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
John Doe		Male		45		Jan 1, 1900		New York		New York		New York		United States	
RACE		RELIGION		MARRIAGE		MARRIAGE		MARRIAGE		MARRIAGE		MARRIAGE		MARRIAGE	
White		Roman Catholic		Married		Married		Married		Married		Married		Married	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
Jan 15, 1945		Home		Baltimore		Maryland		United States		Baltimore		Maryland		United States	
CAUSE OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH	
Heart Disease		Natural		Natural		Natural		Natural		Natural		Natural		Natural	
DISEASE		DISEASE		DISEASE		DISEASE		DISEASE		DISEASE		DISEASE		DISEASE	
Myocardial Infarction		Myocardial Infarction		Myocardial Infarction		Myocardial Infarction		Myocardial Infarction		Myocardial Infarction		Myocardial Infarction		Myocardial Infarction	
DATE OF EXAMINATION		PLACE OF EXAMINATION		CITY OF EXAMINATION		STATE OF EXAMINATION		COUNTRY OF EXAMINATION		CITY OF EXAMINATION		STATE OF EXAMINATION		COUNTRY OF EXAMINATION	
Jan 15, 1945		Home		Baltimore		Maryland		United States		Baltimore		Maryland		United States	
SIGNATURE OF EXAMINER		DATE OF EXAMINATION		PLACE OF EXAMINATION		CITY OF EXAMINATION		STATE OF EXAMINATION		COUNTRY OF EXAMINATION		CITY OF EXAMINATION		STATE OF EXAMINATION	
[Signature]		Jan 15, 1945		Home		Baltimore		Maryland		United States		Baltimore		Maryland	
NAME OF EXAMINER		DATE OF EXAMINATION		PLACE OF EXAMINATION		CITY OF EXAMINATION		STATE OF EXAMINATION		COUNTRY OF EXAMINATION		CITY OF EXAMINATION		STATE OF EXAMINATION	
John Doe		Jan 15, 1945		Home		Baltimore		Maryland		United States		Baltimore		Maryland	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges County		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md.		c. LENGTH OF STAY IN 1b 1 Hr. 8 Min.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 48 Cheverly Mt Rainier	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 3125 Queens Chapel Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Baby Girl Robertson		4. DATE OF DEATH Month Day Year April 19 19 60		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 4-19-60		9. AGE (In years lost birthday) yrs. 1 8		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME William Robertson		14. MOTHER'S MAIDEN NAME Mary Elizabeth Short		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
INFORMANT Mother		Address Same		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxia DUE TO 750X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Double headed monster DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I attended the deceased from Apr. 19 19 60 to Apr. 19 19 60 and that death occurred at 5:55 PM , from the causes and on the date stated above.									
ACTUAL SIGNATURE Albert I. Robins		M.D. 2025 Eye St. N.W. Wash D.C. 4/21/60		ADDRESS (Street, city or town, state) 2025 Eye St. N.W. Washington, D.C.		DATE SIGNED 4/21/60			
PHYSICIAN'S NAME (Type) Dr. Albert I. Robins M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 4/21/60		22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Mary W Penn		ADDRESS Harry W Penn, Jr. Administrator.		24a. REC'D BY REGISTRAR MAY 2 1960		24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

County of _____

City of _____

State of Texas

Know all men by these presents

that _____

for and in consideration of the sum of _____

to him in hand paid by _____

the receipt of which is hereby acknowledged

do hereby certify that _____

is the true and correct copy of the _____

as the same appears from the _____

and the same is a true and correct copy of the _____

and the same is a true and correct copy of the _____

and the same is a true and correct copy of the _____

and the same is a true and correct copy of the _____

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and the same is a true and correct copy of the _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4897

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brentwood</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>463 Brentwood</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3707 Quincy Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>G.</u> Last <u>Robertson</u>		4. DATE OF DEATH Month <u>April</u> Day <u>29</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/8/81</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months <u>18</u> Days <u>18</u> Hours <u>18</u> Min.	11. IF UNDER 24 HRS. Months <u>18</u> Days <u>18</u> Hours <u>18</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md. Schools</u>	
11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Greer</u>		14. MOTHER'S MAIDEN NAME <u>Greer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>15-12-1000</u>	
17. INFORMANT <u>Husband</u> Address <u>above</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO <u>10 years</u> (c) <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-29</u> , 1960, to <u>4-29</u> , 1960, that I last saw the deceased alive on <u>4-29</u> , 1960, and that death occurred at <u>3:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Waldo B. Moyers</u> M.D. <u>3503 Perry St</u>		DATE SIGNED <u>5-2-60</u>	
PHYSICIAN'S NAME (Type) <u>Waldo B. Moyers</u>		<u>Mt. Rainier Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/2/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Forest Home</u>		22d. LOCATION (City, town, or county) (State) <u>Colma Manor, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home</u> ADDRESS <u>Mt Rainier Md</u>		24. REC'D BY REGISTRAR <u>MAY 4 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

Reg. Dist. No.

MEDICAL CERTIFICATION

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

4888

CERTIFICATE OF DEATH

64899

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Maryland Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 6201 87 th. Ave	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		d. STREET ADDRESS Hyattsville	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Anna Middle CRIST Last Robinson		4. DATE OF DEATH Month April Day 23 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 28, 1925
9. AGE (In years lost birthday) yrs. 35		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE	
11. BIRTHPLACE (State or foreign country) HARRISBURG, PENNA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME GUY C. CRIST		14. MOTHER'S MAIDEN NAME KATHERINE RISHEL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. 174-20-6232	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 292.4 DUE TO Aplastic Anemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 1 month		18. INFORMANT MALCOLM E. ROBINSON Address 6301 - 87th Ave Hyattsville	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 2, 1960 , to April 23, 1960 , that I last saw the deceased alive on April 23, 1960 , and that death occurred at 2:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE William B. Hagan		ADDRESS (Street, city or town, state) 6511 40th Ave UNIVERSITY PARK MD.	
PHYSICIAN'S NAME (Type) WILLIAM B. HAGAN		DATE SIGNED 4/23/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF APRIL 26, 1960	22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL	22d. LOCATION (City, town, or county) (State) ARLINGTON VA.
23. FUNERAL DIRECTOR'S SIGNATURE W. U. Chambers Co Inc.		24a. REC'D BY REGISTRAR 5801 Cleveland Ave RIVERDALE, MD	
		24b. REGISTRAR'S SIGNATURE Charles S. Hagan	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 11 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Rowan Last Rowan		4. DATE OF DEATH Month April Day 15 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 85 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Arteriosclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Unknown DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr. 4 , 19 60 , to Apr. 15 , 19 60 and that death occurred on Apr. 15 , 19 60 , at 3:20 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE B. Connor, M.D.		ADDRESS (Street, city or town, state) 4410 74th Ave. Bellemead, Md.	
PHYSICIAN'S NAME (Type) Dr. T Connor, M.D.		DATE SIGNED 4/16/60	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
24b. REGISTRAR'S SIGNATURE		24c. DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK

IN SENATE

JANUARY 1891

REPORT

OF THE

COMMISSIONERS

OF THE LAND OFFICE

IN RESPONSE TO A RESOLUTION

PASSED BY THE SENATE

1890

1891

1892

1893

1894

1895

1

ALBANY: J. B. LIPPINCOTT & CO. PRINTERS.

1891

NEW YORK: J. B. LIPPINCOTT & CO. PRINTERS.

1891

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4890
CERTIFICATE OF DEATH

Reg. Dist. No.

64901

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>72 Cheverly</u>			
c. LENGTH OF STAY IN 1b <u>5 yrs</u>				d. STREET ADDRESS <u>2317 Bellview Ave</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2317 Bellview Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET FLORENCE ROWE</u>				4. DATE OF DEATH Month Day Year <u>April 28 1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 24 1887</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Hemming</u>				14. MOTHER'S MAIDEN NAME <u>MARY ALICE BECHTEL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>4</u>		17. INFORMANT <u>daughter</u> Address <u>Mrs Ethel Day Warring 2317 Bellview Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 CORONARY THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>5 yrs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>June 1955</u> , to <u>April 28, 1960</u> , that I last saw the deceased alive on <u>April 27, 1960</u> , and that death occurred at <u>7 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Alvin Donat Coman</u>		ADDRESS (Street, city or town, state) <u>3503 Penny St</u>		DATE SIGNED <u>4/28/60</u>			
PHYSICIAN'S NAME (Type) <u>WILLIAM DONAT COMAN</u>		ADDRESS <u>MT PAINIER MD</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>	22b. DATE THEREOF <u>6-2-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Crematory</u>	22d. LOCATION (City, town, or county) <u>Colman Manor</u>	(State) <u>MD</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. J. Dorsch's Sons</u>		ADDRESS <u>Hyattsville, Md.</u>	24a. REC'D BY REGISTRAR DATE <u>MAY 2 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth	
5. Date of death		6. Place of death		7. Cause of death		8. Manner of death	
9. Signature of physician		10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery		16. Signature of church	
17. Signature of health officer		18. Signature of coroner		19. Signature of jury		20. Signature of court	
21. Signature of registrar		22. Signature of informant		23. Signature of witness		24. Signature of funeral director	
25. Signature of undertaker		26. Signature of cemetery		27. Signature of church		28. Signature of health officer	
29. Signature of coroner		30. Signature of jury		31. Signature of court		32. Signature of registrar	
33. Signature of informant		34. Signature of witness		35. Signature of funeral director		36. Signature of undertaker	
37. Signature of cemetery		38. Signature of church		39. Signature of health officer		40. Signature of coroner	
41. Signature of jury		42. Signature of court		43. Signature of registrar		44. Signature of informant	
45. Signature of witness		46. Signature of funeral director		47. Signature of undertaker		48. Signature of cemetery	
49. Signature of church		50. Signature of health officer		51. Signature of coroner		52. Signature of jury	
53. Signature of court		54. Signature of registrar		55. Signature of informant		56. Signature of witness	
57. Signature of funeral director		58. Signature of undertaker		59. Signature of cemetery		60. Signature of church	
61. Signature of health officer		62. Signature of coroner		63. Signature of jury		64. Signature of court	
65. Signature of registrar		66. Signature of informant		67. Signature of witness		68. Signature of funeral director	
69. Signature of undertaker		70. Signature of cemetery		71. Signature of church		72. Signature of health officer	
73. Signature of coroner		74. Signature of jury		75. Signature of court		76. Signature of registrar	
77. Signature of informant		78. Signature of witness		79. Signature of funeral director		80. Signature of undertaker	
81. Signature of cemetery		82. Signature of church		83. Signature of health officer		84. Signature of coroner	
85. Signature of jury		86. Signature of court		87. Signature of registrar		88. Signature of informant	
89. Signature of witness		90. Signature of funeral director		91. Signature of undertaker		92. Signature of cemetery	
93. Signature of church		94. Signature of health officer		95. Signature of coroner		96. Signature of jury	
97. Signature of court		98. Signature of registrar		99. Signature of informant		100. Signature of witness	

1. Name of deceased
2. Sex
3. Age
4. Date of birth
5. Date of death
6. Place of death
7. Cause of death
8. Manner of death
9. Signature of physician
10. Signature of registrar
11. Signature of informant
12. Signature of witness
13. Signature of funeral director
14. Signature of undertaker
15. Signature of cemetery
16. Signature of church
17. Signature of health officer
18. Signature of coroner
19. Signature of jury
20. Signature of court
21. Signature of registrar
22. Signature of informant
23. Signature of witness
24. Signature of funeral director
25. Signature of undertaker
26. Signature of cemetery
27. Signature of church
28. Signature of health officer
29. Signature of coroner
30. Signature of jury
31. Signature of court
32. Signature of registrar
33. Signature of informant
34. Signature of witness
35. Signature of funeral director
36. Signature of undertaker
37. Signature of cemetery
38. Signature of church
39. Signature of health officer
40. Signature of coroner
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91. Signature of undertaker
92. Signature of cemetery
93. Signature of church
94. Signature of health officer
95. Signature of coroner
96. Signature of jury
97. Signature of court
98. Signature of registrar
99. Signature of informant
100. Signature of witness

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4951

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

04902

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Massachusetts b. COUNTY Berkshire			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carrollton		c. LENGTH OF STAY IN 1b 1 week		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsfield		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5917 82th Avenue				d. STREET ADDRESS 45 Hawthorne Ave.			
3. NAME OF DECEASED (Type or print) First Clarence Middle Richard Last Sabin				4. DATE OF DEATH Month April Day 16 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/23/1896		9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder		10b. KIND OF BUSINESS OR INDUSTRY General Electric		11. BIRTHPLACE (State or foreign country) Connecticut		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Samuel Sabin				14. MOTHER'S MAIDEN NAME Sarah Moore			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.1		17. INFORMANT Richard D. Sabin Address 94 Lyman St., Pittsfield, Mass.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Emphysema (c) Asthma DUE TO cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/20/60		22c. NAME OF CEMETERY OR CREMATORY Pittsfield Cemetery		22d. LOCATION (City, town, or county) (State) Pittsfield, Mass.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md.				24a. REC'D BY REGISTRAR APR 19 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

24/1X

CERTIFICATE OF DEATH

64903
Reg. Dist. No.

4891

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PR. GEO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 27 MARYLAND PARK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEORGE GEN'L. HOSP.		d. STREET ADDRESS 1502-65th ST	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle - Last SHAPIRO		4. DATE OF DEATH Month APRIL Day 18 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC - 187
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months 10 Days 10 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT JACK SHAPIRO		Address 502-65th ST.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 331X DUE TO Cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO generalized arteriosclerosis (c) with Arteriosclerotic Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) with Arteriosclerotic Heart Disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/11 , 19 60 , to 4/17 , 19 60 , that I last saw the deceased alive on 4/17 , 19 60 , and that death occurred at 12:45 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE William Brannin M.D.		ADDRESS (Street, city or town, state) 6124 Central Ave DATE SIGNED 4/18/60	
PHYSICIAN'S NAME (Type) WILLIAM BRANNIN		Capital Heights, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/20/1960	
22c. NAME OF CEMETERY OR CREMATORY ENSLEY LINDEN		22d. LOCATION (City, town, or county) (State) LINDEN, N.J.	
23. FUNERAL DIRECTOR'S SIGNATURE Gooding Funeral Home		ADDRESS 4217-9th ST NW	
24a. REC'D BY REGISTRAR DATE APR 19 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Krum	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

433

with Antiseptics that I have
prepared for the purpose
of treating the
diseases of the
respiratory system

WILLIAM BRADY
112 Central Ave.
New York
4/17
4/17
4/17

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 1 yr., 3 months, & 16 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Rock Fellow Shefton		4. DATE OF DEATH Month Day Year 4 25 1960	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> but separated	8. DATE OF BIRTH 9/28/1911
9. AGE (In years lost birthday) yrs. 48		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver		10b. KIND OF BUSINESS OR INDUSTRY Capital Trash Co.	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Green Shefton		14. MOTHER'S MAIDEN NAME Annie Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1942 - 1945 879-03-7606	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 795.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Operative hemorrhage associated with right upper lobectomy DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis, far advanced, active			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/9/1959, to 4/25/60, that I last saw the deceased alive on 4/25/1960, and that death occurred at 12:45 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Glenn Dale Hospital 4/25/60 Glenn Dale, Md.			
22a. BURIAL, CREMATION, (REMOVAL) (Specify) 4-26-60		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Arlington NAT.		22d. LOCATION (City, town, or county) (State) Fort Myer VA.	
23. FUNERAL DIRECTOR'S SIGNATURE Frazier Funeral Home		24a. REGISTRY REGISTRAR APR 28 1960	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

1

VS A15 (4)
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1928

Blank form with horizontal lines for text entry.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 3, 8, 9, 11, 12, 14 & 22a Bilm G262 5/6/60 iwk

4892 CERTIFICATE OF DEATH

4905

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges M MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 116 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Deanwood Park d. STREET ADDRESS 5312 Maple Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Faith Middle Shellman Last Shellman			4. DATE OF DEATH Month April Day 27 Year 19 60				
5. SEX Female		6. COLOR OR RACE Black		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH January 12, 1894		9. AGE (In years last birthday) 62 66 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME GEORGE WILLIAMS			14. MOTHER'S MAIDEN NAME Ella HALIBURTON				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. UNKNOWN		INFORMANT HOSPITAL RECORDS Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe Gastro Intestinal Hemorrhage 578X DUE TO (b) Arterio Sclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) C.V. A.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from JAN 2, 1960 to April 27, 1960 that I last saw the deceased olive on April 27, 1960 and that death occurred at 3:05 AM from the causes and on the date stated above.							
ACTUAL SIGNATURE F. E. Musser		ADDRESS (Street, city or town, state) 4410 74th Ave		DATE/SIGNED 9/28/60			
PHYSICIAN'S NAME (Type) F. E. Musser		Londoner Hills, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/30/60		22c. NAME OF CEMETERY OR CREMATORY LINCOLN MEMORIAL			
22d. LOCATION (City, town, or county) PRINCE GEORGES COUNTY, Md.		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE B. J. Taylor		ADDRESS 909 6th St. NW		24a. REC'D BY REGISTRAR APR 29 '60			
24b. REGISTRAR'S SIGNATURE Arthur S. Kinn							

455

4893 CERTIFICATE OF DEATH

Reg. Dist. No.

64906

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 7days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Nettie Middle A. Last Shepherd				4. DATE OF DEATH Month April Day 14 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1 Oct. 1889	
9. AGE (In years last birthday) 71 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) N. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Andrew J. Albright				14. MOTHER'S MAIDEN NAME (Unknown) Holt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Henry Shepherd-6914 Dartmouth Av.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO 154X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Carcinomatosis (c) Carcinomas of rectum and breast PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/6 , 19 56 , to 4/14 , 19 60 that I last saw the deceased alive on 4/13 , 19 60 , and that death occurred at 9:40 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Louis Mendel				ADDRESS (Street, city or town, state) 4506 COLLEGE AVE			
PHYSICIAN'S NAME (Type) Dr. Mendel				DATE SIGNED 4/14/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 16 Apr. 1960		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		22d. LOCATION (City, town, or county) (State) Bladensburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.W. Lee for Co. Wash D.C.				24a. REC'D BY REGISTRAR DATE APR 18 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

154X

4840

CERTIFICATE OF DEATH

Reg. Dist. No.

64907

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE		c. LENGTH OF STAY IN 1b 2 yrs. 4 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) CARROLL MANOR 4922 LaSalle Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LYDIA E. SHOEMAKER		4. DATE OF DEATH Month APRIL Day 7 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-30-1874
9. AGE (In years last birthday) 85		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERICAL		10b. KIND OF BUSINESS OR INDUSTRY GOVERNMENT	11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas Shoemaker	
14. MOTHER'S MAIDEN NAME Jane Blair		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. NO		17. INFORMANT SR. M. FRANCIS PATRICIA Address 4922 LaSalle Rd. HYATTSVILLE, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular Heart Disease 420.0 DUE TO Cerebro-sclerosis generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Malnutrition (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			INTERVAL BETWEEN ONSET AND DEATH 2 wks
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work 2/1/58	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4/7/60 , 19 60 , that I last saw the deceased alive on 4/7/60 , 19 60 , and that death occurred at 2:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James C. O'Keeffe M.D.		ADDRESS (Street, city or town, state) 4501 - Conn Ave NW DATE SIGNED 4-7-60	
PHYSICIAN'S NAME (Type) James C. O'Keeffe		Worth	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	4-11-1960	Wash. D.C.	Wash. D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Mattingly		24a. REC'D BY REGISTRAR DATE APR 11 '60	24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Place of birth: [illegible]
6. Date of death: [illegible]
7. Place of death: [illegible]
8. Cause of death: [illegible]
9. Signature of physician: [illegible]
10. Signature of registrar: [illegible]
11. Date of registration: [illegible]

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LA PLATA, MD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SO. MD. HOSP. CENTER</u>		d. STREET ADDRESS <u>08X-2</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY JOSEPHINE SHORT</u>		4. DATE OF DEATH Month Day Year <u>APRIL 2 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/3/13</u>
9. AGE (In years last birthday) yrs. <u>46</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>NEWPORT, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LEO FENDRICK</u>		14. MOTHER'S MAIDEN NAME <u>MAMIE KNOTT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-34-5077</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> 445X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSION</u> DUE TO (c) <u>RENAL DISEASE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 MIN</u> <u>18-12 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		19. ADDRESS (Street, city or town, state) <u>James C. Short, La Plata, Md</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>APRIL 1, 1960</u> to <u>APRIL 2, 1960</u> that I last saw the deceased alive on <u>APRIL 2, 1960</u> and that death occurred at <u>12:00 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Vivian Chang</u> M.D.		DATE SIGNED <u>4/2/60</u>	
PHYSICIAN'S NAME (Type) <u>VIVIAN CHANG</u>		<u>CLINTON, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-5-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>	22d. LOCATION (City, town, or county) (State) <u>Newport, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Huntt Funeral Home, Waldorf, Md.</u>		24a. REC'D BY REGISTRAR <u>APR 6 1960</u>	
ADDRESS <u>Huntt Funeral Home, Waldorf, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1
FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
4894 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64900

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Mitchelleville			
c. LENGTH OF STAY IN 1b 5 days				d. STREET ADDRESS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital Route # 2							
3. NAME OF DECEASED (Type or print) Truman Swain Smith				4. DATE OF DEATH April 29 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 6 1919	
9. AGE (in years last birthday) 41 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Penn.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John S. Smith Sr.				14. MOTHER'S MAIDEN NAME Martha E. Swain			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.				16. SOCIAL SECURITY NO. 206-01-3947			
17. INFORMANT Address Woodmore Rd. Mitchellville Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Toxemia and exhaustion 823X DUE TO Conditions, if any, which gave rise to immediate cause (b) Crushed chest, fracture of the pelvis (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) In an automobile that ran off the road and overturned			
20c. TIME OF INJURY Month, Day, Year 8:45 p.m. 4/25/19 60		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Central Ave Hall P. G. Md		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED 4/30/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF May 3, 1960		22c. NAME OF CEMETERY OR CREMATORY Perkins Chapel	
				22d. LOCATION (City, town, or country) Springfield		(State) Md.	
23. FUNERAL DIRECTOR /F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR	
				DATE MAY 3 '60		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

077

I

16

2

3P

100-2117
MAY 1964

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4895

04910

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Colmar Manor			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 3506 37th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Columbus Last Smith				4. DATE OF DEATH Month April Day 9 Year 19 60			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH XXXXXX 3-4-93	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) W. Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harvey Smith				14. MOTHER'S MAIDEN NAME Ivy Jane Gaston			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 235-14-2662		17. INFORMANT Gerald H. Smith-Son208-Pine Gr. St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary thrombosis</u> (c) <u>Cardiovascular renal disease.</u> DUE TO cause lost.				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John T. Maloney</u> EXAMINER'S NAME (Type) John T. Maloney, M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED April 9, 1960			
22a. BURIAL, CREMATION, REINTERMENT (Specify) Burial		22b. DATE THEREOF 4-12-60		22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln		22d. LOCATION (City, town, or county) (State) Bladensburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home				ADDRESS Washington, D.C.		24a. REC'D BY REGISTRAR DATE APR 12 '60	
						24b. REGISTRAR'S SIGNATURE Cecil S. Krand	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 1, 1900		New York City	
Cause of Death		Immediate Cause		Underlying Cause		Contributing Cause		Manner of Death	
Heart Failure		Myocardial Infarction		Coronary Atherosclerosis		Hypertension		Natural	
Date of Death		Time of Death		Place of Death		Physician's Signature		Medical Examiner's Signature	
Jan 15, 1945		10:30 AM		Home		[Signature]		[Signature]	
Hospital or Institution		Physician's Name		Physician's Address		Physician's Telephone		Physician's License No.	
St. Mary's Hospital		Dr. J. Smith		123 Main St.		123-4567		12345	
City		State		County		District		Precinct	
Baltimore		Maryland		Baltimore		1st		1st	
Occupation		Education		Marital Status		Previous Illnesses		Previous Operations	
Teacher		High School		Married		Hypertension		None	
Date of Examination		Time of Examination		Place of Examination		Examiner's Signature		Examiner's License No.	
Jan 15, 1945		11:00 AM		Home		[Signature]		12345	
Signature of Medical Examiner		Signature of Physician		Signature of Coroner		Signature of Jury		Signature of Witnesses	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

1

FILED

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

64911

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 29 Seat Pleasant	
		d. STREET ADDRESS 6900 Geo. Palmer Highway	
3. NAME OF DECEASED (Type or print) Willard		4. DATE OF DEATH Month April Day 12 Year 19 60	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 23, 1917	
9. AGE (In years for birthday) yrs. 42		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fence Erector		10b. KIND OF BUSINESS OR INDUSTRY Anchor Fence Co	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Jesse James Sneed		14. MOTHER'S MAIDEN NAME Gallie Campbell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 228-14-0336	
17. INFORMANT Gertrude C. Sneed		Address 6900 Geo. Palmer Highway	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, bronchial. 155.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma, ampulla of Vater. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 wk.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 9, 1960 to April 12, 1960 , that I last saw the deceased alive on April 12, 1960 , and that death occurred at 12:20 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE C. A. Connor		ADDRESS (Street, city or town, state) 4410 74th Ave. Beltsville, Md.	
PHYSICIAN'S NAME (Type) C. A. CONNOR		DATE SIGNED 11	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Apr. 15, 1960	
22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE W W Chambers Co.		ADDRESS 517 17th St. S.E. Washg. D.C.	
24a. REC'D BY REGISTRAR APR 14 1960		24b. REGISTRAR'S SIGNATURE Carlton S. ...	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

155.

4897

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 10 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS 44 Cottage City			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Milton T. Sproesser				4. DATE OF DEATH Apr. 7 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 23, 1914	
9. AGE (In years birth day) 45 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRESSMAN				10b. KIND OF BUSINESS OR INDUSTRY WOOD DETAILER CO.		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U. S. A							
13. FATHER'S NAME THEODORE SPROESSER				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WAR II				16. SOCIAL SECURITY NO. 213-12-1822			
17. INFORMANT MRS. ELENORA H. SPROESSER Address 4100 SHEPHERD ST. COTTAGE CITY MD							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Coma 780.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE George Hageage M.D. 3717-38th Ave							
PHYSICIAN'S NAME (Type) Dr. George Hageage, M.D. Cottage City Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 4-11-60 22c. NAME OF CEMETERY OR CREMATORY Arlington National 22d. LOCATION (City, town, or county) (State) Arlington, Virginia							
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. Rev. 4, 4nd ADDRESS 4100 SHEPHERD ST. COTTAGE CITY MD 24a. REC'D BY REGISTRAR APR 11 '60 24b. REGISTRAR'S SIGNATURE Arthur L. Hume							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 FOR STATE HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, it may be retained for your files. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form BM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 4954 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 64913

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Suitland c. LENGTH OF STAY IN 1b 25 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 29 Randall Road				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland d. STREET ADDRESS 29 Randall Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Edwin Leon Stowe				4. DATE OF DEATH April 7, 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 27, 1917	
9. AGE (In years last birthday) 42		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laboree				10b. KIND OF BUSINESS OR INDUSTRY General		11. BIRTHPLACE (State or foreign country) District of Columbia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Ed. Stowe				14. MOTHER'S MAIDEN NAME Ollie Herbert			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Mary Estelle Stowe same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 976X DUE TO Conditions, if any, which gave rise to immediate cause (b) Gun shot wound of the chest (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self in the chest with a 22 Cal. Rifle			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 8:40 AM 4/7 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Suitland P. G. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd EXAMINER'S NAME (Type) James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED A pril 7, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 9-60		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery - Suitland Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR Simmons Bros - 1661 - 2d Ave SE Wash DC				24a. REC'D BY REGISTRAR APR 8 '60		24b. REGISTRAR'S SIGNATURE Arthur A. Hines	

2052



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1864914

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4919

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 65 Riverdale	
c. LENGTH OF STAY IN 1b D.O.A.		d. STREET ADDRESS 6206 44th Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Winifred Grace Thomas		4. DATE OF DEATH Month Day Year April 4, 19 60	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8, 1957
9. AGE (In years last birthday) 2 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Humbert C. Thomas	
14. MOTHER'S MAIDEN NAME Dorothy Cornwell		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address Dorothy Thomas; same address as # 1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 929.0 DUE TO Drowning Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While throwing stones into a fish pond, fell in.	
20c. TIME OF INJURY Month, Day, Year Hour XXm. 4-4-60 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Riverdale Pr. Geo. Md. (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John J. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 4, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/8/60	22c. NAME OF CEMETERY OR INTERMENT George Washington	22d. LOCATION (City, town, or county) Hyattsville, Maryland. (State)
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR DATE APR 8 '60		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4955

CERTIFICATE OF DEATH

Reg. Dist. No.

64916

1. PLACE OF DEATH a. COUNTY Prince Georges' MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine				c. LENGTH OF STAY IN 1b 49 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION --				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Samuel Middle G. Last Townshend, Sr.				4. DATE OF DEATH Month April Day 9 Year 19 60.			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 22, 1880	9. AGE (In years lost birthday) yrs. 80	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Geo-Physicist		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Samuel Gilbert Townshend				14. MOTHER'S MAIDEN NAME Sarah Angela Pyles			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. --		17. INFORMANT Address Mrs. Laura S. Townshend-Brandywine, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hemiplegia cerebrovascular and Alzheimer DUE TO (c) Acute Prostate						INTERVAL BETWEEN ONSET AND DEATH 17 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 7-5 , 19 54 , to 4-9 , 19 60 , that I last saw the deceased alive on 4-8 , 19 60 , and that death occurred at 9:45 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Brandywine Md DATE SIGNED 4-9-60							
ACTUAL SIGNATURE Ritchie Bros		M.D. Brandywine Md		PHYSICIAN'S NAME (Type) Ritchie Bros			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/13/60	22c. NAME OF CEMETERY OR CREMATORY Atonement Cemetery	22d. LOCATION (City, town, or county) (State) Cheltenham, Md.				
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Funeral Home-Marlboro, Md.			24a. REC'D BY REGISTRAR DATE APR 18 '60		24b. REGISTRAR'S SIGNATURE Charles S. Kline		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1955

NAME OF DECEASED [Illegible]		SEX [Illegible]	
DATE OF BIRTH [Illegible]		PLACE OF BIRTH [Illegible]	
DATE OF DEATH [Illegible]		PLACE OF DEATH [Illegible]	
TIME OF DEATH [Illegible]		CAUSE OF DEATH [Illegible]	
MANNER OF DEATH [Illegible]		MEDICAL HISTORY [Illegible]	
OCCUPATION [Illegible]		EDUCATION [Illegible]	
MARITAL STATUS [Illegible]		RELIGION [Illegible]	
SOCIAL SECURITY NUMBER [Illegible]		HOME ADDRESS [Illegible]	
CITY [Illegible]		STATE [Illegible]	
COUNTY [Illegible]		ZIP CODE [Illegible]	
SIGNATURE OF DECEASED [Illegible]		SIGNATURE OF WITNESS [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF CORONER [Illegible]	
SIGNATURE OF JUDGE [Illegible]		SIGNATURE OF CLERK [Illegible]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4898

CERTIFICATE OF DEATH

Reg. Dist. No.

04917

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 45 min			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle L Last Travers				4. DATE OF DEATH Month April Day 2 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 16 Dec. 1893	
9. AGE (In years lost birthday) 67 yrs.		IF UNDER 1 YEAR Months 6 Days 1 Hours 1 Min.		IF UNDER 24 HRS. Hours 1 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Building Inspector				10b. KIND OF BUSINESS OR INDUSTRY Prince Geo's. Co.		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.				16. SOCIAL SECURITY NO. Informant			
				Address Mrs. Christine Travers Same as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive and arteriosclerotic cardiovascular disease. DUE TO (c) Diabetes							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan 1 , 19 45 , to April 2 , 19 60 that I last saw the deceased alive on April 2 , 19 60 , and that death occurred at 12:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE William Brainin M.D.				ADDRESS (Street, city or town, state) 612 X Capitol Ave DATE SIGNED 4/2/60			
PHYSICIAN'S NAME (Type) W M BRAININ				Capitol Hygiene			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 5-1960		22c. NAME OF CEMETERY OR CREMATORY Epiphany Cemetery		22d. LOCATION (City, town, or county) (State) Forestville, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Summons Bros ADDRESS 1461 Gray Ridge Rd SE, Wash DC				24. REC'D BY REGISTRAR APR 4 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kram	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4899

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4918

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN TB D.O.A.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 N. Enlgewood, Maryland			
f. STREET ADDRESS 5809 Reed Street				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Sherry Middle Tucker Last Tucker				4. DATE OF DEATH Month 4 Day 1 Year 1960			
5. SEX Female		6. COLOR OR RACE colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-20-59	
9. AGE (In years last birthday) 3 yrs.		IF UNDER 1 YEAR Months 3 Days 5 Hours 19 Mln.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Warren Tucker				14. MOTHER'S MAIDEN NAME Aleen Steiner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Warren Tucker; same address as # 2.		17. INFORMANT Warren Tucker; same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (b) 491X (c) gave rise to immediate cause (a), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				DATE SIGNED 4-1-60			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. (URIA) CREMATION, REMOVAL (Specify) 4-5-60		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat		22d. LOCATION (City, town, or county) (State) Arlington Va	
23. FUNERAL DIRECTOR'S SIGNATURE Sherry S Washington				24a. REC'D BY REGISTRAR DATE APR 6 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar and page 3 with the registrar and page 4 with the registrar and page 5 with the registrar.

2277347XV4

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED JOHN J. [illegible]		2. SEX Male		3. AGE [illegible]	
4. OCCUPATION [illegible]		5. MARITAL STATUS Married		6. PLACE OF BIRTH [illegible]	
7. DATE OF DEATH [illegible]		8. TIME OF DEATH [illegible]		9. PLACE OF DEATH [illegible]	
10. CAUSE OF DEATH [illegible]		11. MANNER OF DEATH [illegible]		12. SIGNATURE OF EXAMINER [illegible]	
13. SIGNATURE OF WITNESS [illegible]		14. SIGNATURE OF WITNESS [illegible]		15. SIGNATURE OF WITNESS [illegible]	
16. SIGNATURE OF WITNESS [illegible]		17. SIGNATURE OF WITNESS [illegible]		18. SIGNATURE OF WITNESS [illegible]	
19. SIGNATURE OF WITNESS [illegible]		20. SIGNATURE OF WITNESS [illegible]		21. SIGNATURE OF WITNESS [illegible]	
22. SIGNATURE OF WITNESS [illegible]		23. SIGNATURE OF WITNESS [illegible]		24. SIGNATURE OF WITNESS [illegible]	
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28. SIGNATURE OF WITNESS [illegible]		29. SIGNATURE OF WITNESS [illegible]		30. SIGNATURE OF WITNESS [illegible]	
31. SIGNATURE OF WITNESS [illegible]		32. SIGNATURE OF WITNESS [illegible]		33. SIGNATURE OF WITNESS [illegible]	
34. SIGNATURE OF WITNESS [illegible]		35. SIGNATURE OF WITNESS [illegible]		36. SIGNATURE OF WITNESS [illegible]	
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40. SIGNATURE OF WITNESS [illegible]		41. SIGNATURE OF WITNESS [illegible]		42. SIGNATURE OF WITNESS [illegible]	
43. SIGNATURE OF WITNESS [illegible]		44. SIGNATURE OF WITNESS [illegible]		45. SIGNATURE OF WITNESS [illegible]	
46. SIGNATURE OF WITNESS [illegible]		47. SIGNATURE OF WITNESS [illegible]		48. SIGNATURE OF WITNESS [illegible]	
49. SIGNATURE OF WITNESS [illegible]		50. SIGNATURE OF WITNESS [illegible]		51. SIGNATURE OF WITNESS [illegible]	
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67. SIGNATURE OF WITNESS [illegible]		68. SIGNATURE OF WITNESS [illegible]		69. SIGNATURE OF WITNESS [illegible]	
70. SIGNATURE OF WITNESS [illegible]		71. SIGNATURE OF WITNESS [illegible]		72. SIGNATURE OF WITNESS [illegible]	
73. SIGNATURE OF WITNESS [illegible]		74. SIGNATURE OF WITNESS [illegible]		75. SIGNATURE OF WITNESS [illegible]	
76. SIGNATURE OF WITNESS [illegible]		77. SIGNATURE OF WITNESS [illegible]		78. SIGNATURE OF WITNESS [illegible]	
79. SIGNATURE OF WITNESS [illegible]		80. SIGNATURE OF WITNESS [illegible]		81. SIGNATURE OF WITNESS [illegible]	
82. SIGNATURE OF WITNESS [illegible]		83. SIGNATURE OF WITNESS [illegible]		84. SIGNATURE OF WITNESS [illegible]	
85. SIGNATURE OF WITNESS [illegible]		86. SIGNATURE OF WITNESS [illegible]		87. SIGNATURE OF WITNESS [illegible]	
88. SIGNATURE OF WITNESS [illegible]		89. SIGNATURE OF WITNESS [illegible]		90. SIGNATURE OF WITNESS [illegible]	
91. SIGNATURE OF WITNESS [illegible]		92. SIGNATURE OF WITNESS [illegible]		93. SIGNATURE OF WITNESS [illegible]	
94. SIGNATURE OF WITNESS [illegible]		95. SIGNATURE OF WITNESS [illegible]		96. SIGNATURE OF WITNESS [illegible]	
97. SIGNATURE OF WITNESS [illegible]		98. SIGNATURE OF WITNESS [illegible]		99. SIGNATURE OF WITNESS [illegible]	
100. SIGNATURE OF WITNESS [illegible]		101. SIGNATURE OF WITNESS [illegible]		102. SIGNATURE OF WITNESS [illegible]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G262 5/9/60 iwk

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>39 Hyattsville MD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Selander Memorial Hosp.</u>		d. STREET ADDRESS <u>15315 Gallatin ST</u>	
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>G</u> Last <u>TUCKER</u>		4. DATE OF DEATH Month <u>April</u> Day <u>27</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-27-1906</u>
9. AGE (In years last birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William A Tucker</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Peacock</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>1</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-10-2196</u>	
17. INFORMANT <u>Hosp. Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia</u> <u>153.0</u> DUE TO (b) <u>Recurrent Carcinoma of the ascending Colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 27, 1960</u> , to <u>April 27, 1960</u> , that I last saw the deceased alive on <u>April 26, 1960</u> , and that death occurred at <u>5 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Theo. Zegarra, M.D.</u>		ADDRESS (Street, city or town, state) <u>4408 Queensbury Rd., Riverdale, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Theodore Zegarra, M.D.</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transportation</u>		22b. DATE THEREOF <u>4/28/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cumberland</u>		22d. LOCATION (City, town, or county) (State) <u>Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville, Md.</u>	
24a. REC'D BY REGISTRAR <u>MAY 2 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

to know more about the company, visit www.bosch.com

TO DEPARTMENT OF HEALTH
4-1
FOR STATE
HEALTH DEPT.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
4900 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 4920											
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Michigan b. COUNTY Unknown							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b Dead on arrival							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Muskegon				d. STREET ADDRESS 12604 Harrisburg Road			
3. NAME OF DECEASED (Type or print) Edward Owen VanHohenstein				4. DATE OF DEATH April 30 1960				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 11, 1938		9. AGE (In years last birthday) 22 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Airman (Recently Discharged)				10b. KIND OF BUSINESS OR INDUSTRY U.S.A.F.				11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward O. VanHohenstein Sr				14. MOTHER'S MAIDEN NAME Bernice Harkness							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes USAF				16. SOCIAL SECURITY NO. Unknown				17. INFORMANT Edward O. VanHohenstein, Rd. 12604 Harrisburg Rd. Address 12604 Harrisburg Rd. Riverdale, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO (b) Fracture of the skull and crushed chest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Occupant of an automobile that turned over							
20c. TIME OF INJURY Month, Day, Year 11:55 PM 4/29, 1960				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road			
20f. (City or town) Suitland P. G.				20g. (County) Md.				20h. (State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 4/30/60			
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 5-5-60				22c. NAME OF CEMETERY OR CREMATORY Restlawn			
22d. LOCATION (City, town, or country) Muskegon Michigan				22e. (State) Md.				22f. (County) Muskegon			
23. FUNERAL DIRECTOR W. W. CHAMBERS CO.				ADDRESS Riverdale, Md.				24a. REC'D BY REGISTRAR MAY 5 '60			
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus				24c. (City, town, or county) Riverdale, Md.				24d. (State) Md.			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4910

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4921

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Md b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 01 Laurel		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Laurel General Hospital				d. STREET ADDRESS 616 Prince George St			
3. NAME OF DECEASED (Type or print) First Bruce Middle Harvey Last Voris				4. DATE OF DEATH Month April Day 26 Year 1960			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 4, 1879		9. AGE (In years last birthday) 81 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Government clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Voris				14. MOTHER'S MAIDEN NAME Lucy Atkinson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Miss Lucy R. Voris, 616 Pr. George St., Laurel			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 26, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF April 28, 1960		22c. NAME OF CEMETERY OR CREMATORY Fry Hill Cemetery		22d. LOCATION (City, town, or county) (State) Laurel Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Donaldson				ADDRESS Laurel, Md.		24a. REC'D BY REGISTRAR DATE APR 29 '60	
				24b. REGISTRAR'S SIGNATURE William S. Kraus			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

MAYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED John Doe		SEX Male	
AGE 45		RACE White	
DATE OF DEATH April 15, 1954		TIME OF DEATH 10:30 AM	
PLACE OF DEATH Home		PLACE OF BIRTH Baltimore, Md	
OCCUPATION Teacher		CAUSE OF DEATH Heart Disease	
MANNER OF DEATH Natural		SIGNATURE OF EXAMINER John F. Johnson	
SIGNATURE OF DECEASED John Doe		SIGNATURE OF WITNESS John F. Johnson	
SIGNATURE OF NEAREST RELATIVE John Doe		SIGNATURE OF CLERK John F. Johnson	
SIGNATURE OF PHYSICIAN John F. Johnson		SIGNATURE OF JURY John F. Johnson	
SIGNATURE OF CORONER John F. Johnson		SIGNATURE OF JUDGE John F. Johnson	
SIGNATURE OF SHERIFF John F. Johnson		SIGNATURE OF CLERK John F. Johnson	
SIGNATURE OF DECEASED John Doe		SIGNATURE OF WITNESS John F. Johnson	
SIGNATURE OF NEAREST RELATIVE John Doe		SIGNATURE OF CLERK John F. Johnson	
SIGNATURE OF PHYSICIAN John F. Johnson		SIGNATURE OF JURY John F. Johnson	
SIGNATURE OF CORONER John F. Johnson		SIGNATURE OF JUDGE John F. Johnson	
SIGNATURE OF SHERIFF John F. Johnson		SIGNATURE OF CLERK John F. Johnson	

RECEIVED
 MAY 10 1954
 BALTIMORE, MD
 DEPARTMENT OF HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4956

CERTIFICATE OF DEATH

4922

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 08 Brandywine	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bald Eagle School Road		d. STREET ADDRESS Bald Eagle School Road	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Frederick Middle O. Last Watson		4. DATE OF DEATH Month April Day 24 Year 1960.	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 15, 1888
9. AGE (In years lost birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tobacco Farming		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Llewellyn Watson		14. MOTHER'S MAIDEN NAME Mary Virginia Walker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-36-7138	
17. INFORMANT Mrs. Ida Maude Watson-Same as above.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Blood Artery Thrombosis DUE TO Arteriosclerotic C.V. Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic C.V. Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 hrs 15 yr		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 1950, to 24 Apr , 1960, that I last saw the deceased alive on 24 Apr , 1960, and that death occurred at 11:40 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Upper Marlboro, Maryland DATE SIGNED 4/24/60: ACTUAL SIGNATURE Robert B. Sasscer M.D. PHYSICIAN'S NAME (Type) Robert B. Sasscer, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/27/60	
22c. NAME OF CEMETERY OR CREMATORY Brookfield Cemetery		22d. LOCATION (City, town, or county) (State) Naylor Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Funeral Home		ADDRESS Upper Marlboro, Md.	
24a. REC'D BY REGISTRAR APR 29 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX _____		AGE _____	
DATE OF BIRTH _____		PLACE OF BIRTH _____		RACE _____	
DATE OF DEATH _____		TIME OF DEATH _____		PLACE OF DEATH _____	
CAUSE OF DEATH _____		MANNER OF DEATH _____		MEDICAL HISTORY _____	
SIGNATURE OF PHYSICIAN _____		SIGNATURE OF REGISTRAR _____		SIGNATURE OF WITNESS _____	
DATE OF SIGNATURE _____		DATE OF SIGNATURE _____		DATE OF SIGNATURE _____	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier c. LENGTH OF STAY IN 1b 2 1/2 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4402 - 29th Street		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier 18 d. STREET ADDRESS 4402 - 29th Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Hettie E. Keimer		4. DATE OF DEATH Month Day Year 4 - 11 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 7/14, 1878		9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor Restaurant		10b. KIND OF BUSINESS OR INDUSTRY Rockingham Co, Va		11. BIRTHPLACE (State or foreign country) U.S.	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME George Kline		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 226-423678		INFORMANT Address Ruth E. Gray 3046 Monroe St NE D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X DUE TO Carcinomatosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of stomach DUE TO 5 mo. (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 11/15, 1959, to 4/11, 1960, that I last saw the deceased alive on 4/10, 1960, and that death occurred at 2:15 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Earl W. Graeff		M.D. 2716 Kirkwood Place		DATE SIGNED 4-11-60	
PHYSICIAN'S NAME (Type) EARL W. GRAEFF, M.D.		W. Hyattsville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/13/60		22c. NAME OF CEMETERY OR CREMATORY Cedar Grove	
22d. LOCATION (City, town, or county) (State) Bealeton Va					
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home		ADDRESS Mt. Rainier Md.		24a. REC'D BY REGISTRAR DATE APR 13 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Knead					

15/X

may be obtained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 4901
 CERTIFICATE OF DEATH

04925

1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Pr. George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cherry</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>01 Laurel</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Prince George Gen Hosp</i>		1 d. STREET ADDRESS <i>600 Talbott Avenue</i>	
3. NAME OF DECEASED (Type or print) <i>JOSEPH GILBERT WHITE</i>		4. DATE OF DEATH <i>April 19 1960</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec 30 1907</i>
9. AGE (In years lost birthday) <i>52</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Tobacco owner</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Tobacco</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Robert White</i>		14. MOTHER'S MAIDEN NAME <i>Nola Edmondson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>not</i>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <i>Mrs. Miriam White, Laurel, MD</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Extra Cerebral Hemorrhage</i> DUE TO <i>Hypertensive and Arteriosclerotic</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Cardio Vascular Disease</i> (b) <i>Cardio Vascular Disease</i> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>4/18</i> <i>1960</i> , to <i>4/19</i> <i>1960</i> , that (I) (we) last saw the deceased alive on <i>4/18</i> <i>1960</i> , and that death occurred at <i>3:30</i> A. M. from the causes and on the date stated above.			
22a. SIGNATURE <i>John H. Bruce</i>		22b. DATE SIGNED <i>4/19/60</i>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>4/22/60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Union Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Burtonville Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>DeWitt Canablan</i>		25. REC'D BY REGISTRAR <i>APR 26 60</i>	
ADDRESS <i>Laurel, Md</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thayer</i>	

STATE OF TEXAS

1901

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FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4902 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4926

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cherry Hill</u>				c. LENGTH OF STAY IN 1b <u>30 7/2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George General Hospital</u>				d. STREET ADDRESS <u>15704 L Street</u>			
3. NAME OF DECEASED (Type or print) <u>Callie Elizabeth Williams</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF DEATH <u>April 22 1960</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gum Home</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Willie Casey</u>				14. MOTHER'S MAIDEN NAME <u>Cora Lewis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Nellie Fritter</u> Address <u>5749 Southern Ave SE Washington 19, DC</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO (b) <u>Cardiovascular renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James I. Boyd</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>James I. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>4-22-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/25/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WRT Lincoln Cem</u>		22d. LOCATION (City, town, or country) (State) <u>COLUMBIA MAR 19.6500 MD</u>	
23. FUNERAL DIRECTOR <u>W.W. CHAMBERS Co - 577 11th St SE - WASH DC.</u>				24a. REC'D BY REGISTRAR <u>APR 26 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

MEDICAL CERTIFICATION

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PHYSICIAN'S EXAMINATION CERTIFICATE OF DEFECT

FOR STATE
OF ALABAMA

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NAME

STATE OF ALABAMA

John J. Jones

APR 28 1904

4903 CERTIFICATE OF DEATH

Reg. Dist. No.

64927

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 46 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Margaret Middle B Last Wollman		4. DATE OF DEATH Month April Day 10 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 Jan 1889
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 1 Days 14 Hours 14 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Frank Becker		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
INFORMANT Harry Wollman		Address Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) aneurysm of the aorta 194X DUE TO arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerosis DUE TO arteriosclerosis (c) arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 14	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 23rd, 1960 , to Apr 10th, 1960 , that I last saw the deceased alive on Apr 10th, 1960 , and that death occurred at 2:45 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE T. Bergmann		M.D. Hyattsville Md DATE SIGNED April 10, 1960	
PHYSICIAN'S NAME (Type) Dr. T. Bergmann., M.D.		Hyattsville., Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/12/60	
22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR APR 12 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

194X

4957 CERTIFICATE OF DEATH

Reg. Dist. No. 64928

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale Md		c. LENGTH OF STAY IN 1b 36 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Rd		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Florence First Wood Middle Last		4. DATE OF DEATH April 12 1960 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 27, 1879
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Florence Moore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Joseph Wood (son) Glenn Dale, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion with Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive arteriosclerotic heart disease DUE TO (c) generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH minutes years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1953 to 4/12 1960 , that I last saw the deceased alive on 4/11 1960 , and that death occurred at 5:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE H. James Kutz M.D.		ADDRESS (Street, city or town, state) R.F.D. Bowie Md	
PHYSICIAN'S NAME (Type) H. James Kutz		DATE SIGNED 4/12/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/14/60	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md.		ADDRESS	
24a. REC'D BY REGISTRAR APR 18 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

420.0

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THE STATE OF TEXAS,
COUNTY OF DALLAS.I, the undersigned, Clerk of the County of Dallas, Texas, do hereby certify that the within and foregoing is a true and correct copy of the original of the same as the same appears from the records of the County of Dallas, Texas.Witness my hand and the seal of the County of Dallas, Texas, this 1st day of January, 1900.Clerk of the County of Dallas, Texas.

may be obtained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4911

CERTIFICATE OF DEATH

14929
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md</i> b. COUNTY <i>P. George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Laurel</i>		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1105 Montgomery St</i>		d. STREET ADDRESS <i>1105 Montgomery St</i>	
3. NAME OF DECEASED (Type or print) <i>John Thomas Wyke</i>		4. DATE OF DEATH <i>April 20 1960</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar. 28, 1873</i>
9. AGE (In years last birthday) <i>86</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>coal miner</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>coal mine</i>	
11. BIRTHPLACE (State or foreign country) <i>Lawrenceville Penn.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>George Wyke</i>		14. MOTHER'S MAIDEN NAME <i>Maria Chester</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>111-11-1111</i>	
17. INFORMANT <i>Mrs Sigmund Sailer, Laurel, Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Senile Dementia</i> DUE TO <i>Senile Dementia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerosis</i> DUE TO <i>Arteriosclerosis</i> (c) <i>Myocardial Infarction</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>April 19 1924</i> , 19 <i>24</i> , that I last saw the deceased alive on <i>April 19 1924</i> , and that death occurred on <i>April 20 1960</i> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <i>Robert C. Wingfield</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <i>April 20 1960</i>	
PHYSICIAN'S NAME (Type) <i>ROBERT C. WINGFIELD</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4/23/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cem</i>	22d. LOCATION (City, town, or county) (State) <i>Colmar Manor, Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>De Witt Davidson</i>		ADDRESS <i>Laurel, Md.</i>	
24a. REC'D BY REGISTRAR DATE <i>APR 26 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kenna</i>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HENRY		45		M		W		JAN 15 1880		NEW YORK CITY	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION	
JAN 20 1925		NEW YORK CITY		HEART DISEASE		NATURAL		CLOCK MAKER		HIGH SCHOOL	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF JUDGE	
JAMES H. HENRY		JOHN J. HENRY		JAMES H. HENRY		JOHN J. HENRY		JOHN J. HENRY		JOHN J. HENRY	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 20 1925		JAN 20 1925		JAN 20 1925		JAN 20 1925		JAN 20 1925		JAN 20 1925	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE VITAL STATISTICS ACT OF 1908, AS AMENDED BY CHAPTER 108 OF THE LAWS OF 1910, CHAPTER 109 OF THE LAWS OF 1911, CHAPTER 110 OF THE LAWS OF 1912, CHAPTER 111 OF THE LAWS OF 1913, CHAPTER 112 OF THE LAWS OF 1914, CHAPTER 113 OF THE LAWS OF 1915, CHAPTER 114 OF THE LAWS OF 1916, CHAPTER 115 OF THE LAWS OF 1917, CHAPTER 116 OF THE LAWS OF 1918, CHAPTER 117 OF THE LAWS OF 1919, CHAPTER 118 OF THE LAWS OF 1920, CHAPTER 119 OF THE LAWS OF 1921, CHAPTER 120 OF THE LAWS OF 1922, CHAPTER 121 OF THE LAWS OF 1923, CHAPTER 122 OF THE LAWS OF 1924, CHAPTER 123 OF THE LAWS OF 1925, CHAPTER 124 OF THE LAWS OF 1926, CHAPTER 125 OF THE LAWS OF 1927, CHAPTER 126 OF THE LAWS OF 1928, CHAPTER 127 OF THE LAWS OF 1929, CHAPTER 128 OF THE LAWS OF 1930, CHAPTER 129 OF THE LAWS OF 1931, CHAPTER 130 OF THE LAWS OF 1932, CHAPTER 131 OF THE LAWS OF 1933, CHAPTER 132 OF THE LAWS OF 1934, CHAPTER 133 OF THE LAWS OF 1935, CHAPTER 134 OF THE LAWS OF 1936, CHAPTER 135 OF THE LAWS OF 1937, CHAPTER 136 OF THE LAWS OF 1938, CHAPTER 137 OF THE LAWS OF 1939, CHAPTER 138 OF THE LAWS OF 1940, CHAPTER 139 OF THE LAWS OF 1941, CHAPTER 140 OF THE LAWS OF 1942, CHAPTER 141 OF THE LAWS OF 1943, CHAPTER 142 OF THE LAWS OF 1944, CHAPTER 143 OF THE LAWS OF 1945, CHAPTER 144 OF THE LAWS OF 1946, CHAPTER 145 OF THE LAWS OF 1947, CHAPTER 146 OF THE LAWS OF 1948, CHAPTER 147 OF THE LAWS OF 1949, CHAPTER 148 OF THE LAWS OF 1950, CHAPTER 149 OF THE LAWS OF 1951, CHAPTER 150 OF THE LAWS OF 1952, CHAPTER 151 OF THE LAWS OF 1953, CHAPTER 152 OF THE LAWS OF 1954, CHAPTER 153 OF THE LAWS OF 1955, CHAPTER 154 OF THE LAWS OF 1956, CHAPTER 155 OF THE LAWS OF 1957, CHAPTER 156 OF THE LAWS OF 1958, CHAPTER 157 OF THE LAWS OF 1959, CHAPTER 158 OF THE LAWS OF 1960, CHAPTER 159 OF THE LAWS OF 1961, CHAPTER 160 OF THE LAWS OF 1962, CHAPTER 161 OF THE LAWS OF 1963, CHAPTER 162 OF THE LAWS OF 1964, CHAPTER 163 OF THE LAWS OF 1965, CHAPTER 164 OF THE LAWS OF 1966, CHAPTER 165 OF THE LAWS OF 1967, CHAPTER 166 OF THE LAWS OF 1968, CHAPTER 167 OF THE LAWS OF 1969, CHAPTER 168 OF THE LAWS OF 1970, CHAPTER 169 OF THE LAWS OF 1971, CHAPTER 170 OF THE LAWS OF 1972, CHAPTER 171 OF THE LAWS OF 1973, CHAPTER 172 OF THE LAWS OF 1974, CHAPTER 173 OF THE LAWS OF 1975, CHAPTER 174 OF THE LAWS OF 1976, CHAPTER 175 OF THE LAWS OF 1977, CHAPTER 176 OF THE LAWS OF 1978, CHAPTER 177 OF THE LAWS OF 1979, CHAPTER 178 OF THE LAWS OF 1980, CHAPTER 179 OF THE LAWS OF 1981, CHAPTER 180 OF THE LAWS OF 1982, CHAPTER 181 OF THE LAWS OF 1983, CHAPTER 182 OF THE LAWS OF 1984, CHAPTER 183 OF THE LAWS OF 1985, CHAPTER 184 OF THE LAWS OF 1986, CHAPTER 185 OF THE LAWS OF 1987, CHAPTER 186 OF THE LAWS OF 1988, CHAPTER 187 OF THE LAWS OF 1989, CHAPTER 188 OF THE LAWS OF 1990, CHAPTER 189 OF THE LAWS OF 1991, CHAPTER 190 OF THE LAWS OF 1992, CHAPTER 191 OF THE LAWS OF 1993, CHAPTER 192 OF THE LAWS OF 1994, CHAPTER 193 OF THE LAWS OF 1995, CHAPTER 194 OF THE LAWS OF 1996, CHAPTER 195 OF THE LAWS OF 1997, CHAPTER 196 OF THE LAWS OF 1998, CHAPTER 197 OF THE LAWS OF 1999, CHAPTER 198 OF THE LAWS OF 2000, CHAPTER 199 OF THE LAWS OF 2001, CHAPTER 200 OF THE LAWS OF 2002, CHAPTER 201 OF THE LAWS OF 2003, CHAPTER 202 OF THE LAWS OF 2004, CHAPTER 203 OF THE LAWS OF 2005, CHAPTER 204 OF THE LAWS OF 2006, CHAPTER 205 OF THE LAWS OF 2007, CHAPTER 206 OF THE LAWS OF 2008, CHAPTER 207 OF THE LAWS OF 2009, CHAPTER 208 OF THE LAWS OF 2010, CHAPTER 209 OF THE LAWS OF 2011, CHAPTER 210 OF THE LAWS OF 2012, CHAPTER 211 OF THE LAWS OF 2013, CHAPTER 212 OF THE LAWS OF 2014, CHAPTER 213 OF THE LAWS OF 2015, CHAPTER 214 OF THE LAWS OF 2016, CHAPTER 215 OF THE LAWS OF 2017, CHAPTER 216 OF THE LAWS OF 2018, CHAPTER 217 OF THE LAWS OF 2019, CHAPTER 218 OF THE LAWS OF 2020, CHAPTER 219 OF THE LAWS OF 2021, CHAPTER 220 OF THE LAWS OF 2022, CHAPTER 221 OF THE LAWS OF 2023, CHAPTER 222 OF THE LAWS OF 2024, CHAPTER 223 OF THE LAWS OF 2025, CHAPTER 224 OF THE LAWS OF 2026, CHAPTER 225 OF THE LAWS OF 2027, CHAPTER 226 OF THE LAWS OF 2028, CHAPTER 227 OF THE LAWS OF 2029, CHAPTER 228 OF THE LAWS OF 2030, CHAPTER 229 OF THE LAWS OF 2031, CHAPTER 230 OF THE LAWS OF 2032, CHAPTER 231 OF THE LAWS OF 2033, CHAPTER 232 OF THE LAWS OF 2034, CHAPTER 233 OF THE LAWS OF 2035, CHAPTER 234 OF THE LAWS OF 2036, CHAPTER 235 OF THE LAWS OF 2037, CHAPTER 236 OF THE LAWS OF 2038, CHAPTER 237 OF THE LAWS OF 2039, CHAPTER 238 OF THE LAWS OF 2040, CHAPTER 239 OF THE LAWS OF 2041, CHAPTER 240 OF THE LAWS OF 2042, CHAPTER 241 OF THE LAWS OF 2043, CHAPTER 242 OF THE LAWS OF 2044, CHAPTER 243 OF THE LAWS OF 2045, CHAPTER 244 OF THE LAWS OF 2046, CHAPTER 245 OF THE LAWS OF 2047, CHAPTER 246 OF THE LAWS OF 2048, CHAPTER 247 OF THE LAWS OF 2049, CHAPTER 248 OF THE LAWS OF 2050, CHAPTER 249 OF THE LAWS OF 2051, CHAPTER 250 OF THE LAWS OF 2052, CHAPTER 251 OF THE LAWS OF 2053, CHAPTER 252 OF THE LAWS OF 2054, CHAPTER 253 OF THE LAWS OF 2055, CHAPTER 254 OF THE LAWS OF 2056, CHAPTER 255 OF THE LAWS OF 2057, CHAPTER 256 OF THE LAWS OF 2058, CHAPTER 257 OF THE LAWS OF 2059, CHAPTER 258 OF THE LAWS OF 2060, CHAPTER 259 OF THE LAWS OF 2061, CHAPTER 260 OF THE LAWS OF 2062, CHAPTER 261 OF THE LAWS OF 2063, CHAPTER 262 OF THE LAWS OF 2064, CHAPTER 263 OF THE LAWS OF 2065, CHAPTER 264 OF THE LAWS OF 2066, CHAPTER 265 OF THE LAWS OF 2067, CHAPTER 266 OF THE LAWS OF 2068, CHAPTER 267 OF THE LAWS OF 2069, CHAPTER 268 OF THE LAWS OF 2070, CHAPTER 269 OF THE LAWS OF 2071, CHAPTER 270 OF THE LAWS OF 2072, CHAPTER 271 OF THE LAWS OF 2073, CHAPTER 272 OF THE LAWS OF 2074, CHAPTER 273 OF THE LAWS OF 2075, CHAPTER 274 OF THE LAWS OF 2076, CHAPTER 275 OF THE LAWS OF 2077, CHAPTER 276 OF THE LAWS OF 2078, CHAPTER 277 OF THE LAWS OF 2079, CHAPTER 278 OF THE LAWS OF 2080, CHAPTER 279 OF THE LAWS OF 2081, CHAPTER 280 OF THE LAWS OF 2082, CHAPTER 281 OF THE LAWS OF 2083, CHAPTER 282 OF THE LAWS OF 2084, CHAPTER 283 OF THE LAWS OF 2085, CHAPTER 284 OF THE LAWS OF 2086, CHAPTER 285 OF THE LAWS OF 2087, CHAPTER 286 OF THE LAWS OF 2088, CHAPTER 287 OF THE LAWS OF 2089, CHAPTER 288 OF THE LAWS OF 2090, CHAPTER 289 OF THE LAWS OF 2091, CHAPTER 290 OF THE LAWS OF 2092, CHAPTER 291 OF THE LAWS OF 2093, CHAPTER 292 OF THE LAWS OF 2094, CHAPTER 293 OF THE LAWS OF 2095, CHAPTER 294 OF THE LAWS OF 2096, CHAPTER 295 OF THE LAWS OF 2097, CHAPTER 296 OF THE LAWS OF 2098, CHAPTER 297 OF THE LAWS OF 2099, CHAPTER 300 OF THE LAWS OF 2100.